

Correspondence – Health Care [2]

Folder Citation: Collection: Records of the 1976 Campaign Committee to Elect Jimmy Carter;
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http://www.jimmycarterlibrary.gov/library/findingaids/Carter-Mondale%20Campaign_1976.pdf

Handwritten mark

187 West Lincoln Avenue
Delaware, Ohio 43015
June 21, 1976

The Honorable Jimmy Carter
Plains City, Georgia

Sir:

The enclosed article disturbs us. The present condition of the nation disturbs us!

We were hoping for a name to come forth as a "chosen" name to help America see more clearly the God intended way of life.

My sons are 4.0 students. They have been chosen as the trophy winners for character and scholarship. A few weeks before their father's (a former judge and attorney) death- most unexpected and shocking- he had said to them words that now seem almost as if it had been Divine plan for them to have been spoken at that time....

"The more we have been given, the more we must in turn give. My sons, you have been deeply blessed. Give freely of these blessings. The nation is in serious need".

Neither son has forgotten these words. Kevin is now at Boys State-elected Speaker of the House. He is genuinely concerned about existing situations.

I gave a Graduation address a short time ago and many people came up to me showing confusion and need.

Living is not a "joy ride"to us..

Mrs. Carter's statement makes us now wonder if your name is really the "chosen" name as we had quite seriously thought.

Your friend who has a son in jail- caught with a "SMALL" amount of marijuana---?? We have a friend- in the hospital physically handicapped for the rest of his life-- wife- dead- little daughter- a vegetable the rest of her life- could have been your family-- or ours, Mr. Carter-- all because of a person caught with a SMALL amount of marijuana-- and driving very recklessly because of a marijuana kick.....

Also, Mrs. Carter's statement that her first priority, if she does become first lady would be in the field of mental health. Have you seriously looked at the condition of the colleges in this country- the waste the lack of morality- both sons say, "Mother, the deterioration of the family means the deterioration of our nation".-- why are these students feeling the need of drugs, alcohol, and not "love " as they say- it's plain sex.- unless-

June 21, 1976

their families are shirking in their responsibilities to one of God's greatest gifts to wives and Mothers- their children-? Some of our top minds are being thwarted with the existing conditions on college grounds. These minds are needed and should be directed toward a greater productivity and love of learning- The young people are not to blame-- they want direction- but in a free- loving- respectful way.. Mental health is indeed an admirable field and much needs to be done-- but I hear no one speaking of the deplorable situation-- such waste-- on the college level- where the nation should be receiving tremendous assistance.

Deterioration of the home and education-- America will never be defeated from without--- but if this continues, we shall be defeated from within.

To cast our vote for Jimmy Carter- and recommend support for Jimmy Carter-- please let us know--

If you favor decriminalizing marijuana- what is your plan alternatively speaking- to help correct and eliminate this situation?

Thanks for letter

Governor Carter is deeply religious man - believes moderate, decent, Christian behavior is central to restoration & preservation of our important values.

Governor Carter believes

that possession of small

amounts of marijuana

should be a civil-not criminal - offense. Up to

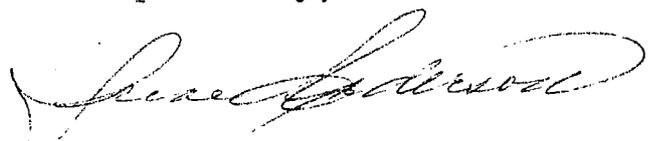
individual states. Vigorous prosecution of dealers & pushers is essential.

Thanks again for writing.

Sincerely,

NSA

Respectfully,



(Mrs. John R. Anderson)

August 16, 1976

Mrs. John R. Anderson
187 West Lincoln Avenue
Delaware, Ohio 43015

Dear Mrs. Anderson:

Thank you for your letter to Governor Carter.

Governor Carter is a deeply religious man who believes that moderate, decent Christian behavior is central to restoration and preservation of our important values.

Governor Carter believes that possession of small amounts of marijuana should be a civil, not a criminal, offense, and that the matter should be resolved by individual states. He feels, however, that vigorous prosecution of dealers and pushers is essential.

Thank you for your interest.

Sincerely,

Robert S. Havely
National Issues and Policies

RSH:dan

Lynn Carter cites problems across nation

COLUMBUS (UPI) — Rosalynn Carter, wife of Democratic presidential hopeful Jimmy Carter, says she and her husband favor decriminalization—but not legalization—of marijuana.

"I am not for legalizing marijuana and neither is Jimmy," Mrs. Carter said in a speech Wednesday to a Democratic Women's luncheon in Columbus. "But I am for decriminalizing it."

She talked about a friend in Georgia who has a 16-year-old son in jail because he was caught with a very small amount of marijuana.

"I think the pushers should be punished severely, but it is very bad for a child to have that criminal record," she said.

Mrs. Carter also said she had worked in women's health services and has seen women permanently damaged by illegal abortions.

"We've seen the problems in Georgia and had to write a new law when Jimmy was governor," she said. "We decided that it was best to leave the constitution the way it is and discuss family planning as alternatives."

When asked about the lack of privacy as the wife of a candidate, she said "we were born and grew up and still live in Plains, Ga., which has a population of 683 and everybody has known everything we did."

She said her first priority, if she does become First Lady, would be in the field of mental health since she has worked in that area at home for six years and then possibly day care centers.

"I see things as I travel across the country, and especially day care centers in almost every community," she said. "Some of them have had their funds cut off and the families are having to go back on welfare."

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



Leaders, for a change.

September 10, 1976

Martin E. Glasser, M.D.
3241 Sacramento Street
San Francisco, California 94115

Dear Mr. Glasser:

Thank you very much for your kind letter of September 2nd, and for your expression of support. I am enclosing several documents which may be of value in your analysis of Governor Carter's position on health policy issues.

These speeches and position papers reflect very well the Governor's philosophy on the questions you raise in your letter. However, in many cases he has not yet developed mechanisms or structures to implement these views. We are working hard to generate alternative proposals for financing and service delivery reform that are workable, clear, and fair, and in the midst of a political campaign that is often a difficult task.

We are attempting to collect the recommendations and insights of many individuals, from providers of care, consumer groups, and policy professionals to insurance specialists, economists, and community leaders. In this regard I would strongly invite the suggestions of the group you represent.

Governor Carter believes that we must provide all our people access to high quality medical care at a cost they - and our nation - can afford. He believes that preventive care and the early detection and prevention of the major cripplers and killers of our people must be stressed. He is convinced that improvements in our environment, education, lifestyle, and living conditions are very important in implementing a strategy for health care reform.

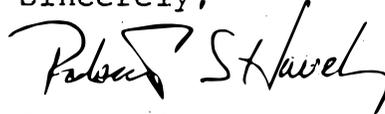
On the subject of National Health Insurance, the Governor believes that reform of the delivery system must accompany financing reform. He supports a phased-in program of health insurance which provides strong cost and quality controls, stimulates the availability of quality care, provides protection for individuals and families,



and guarantees the integrity of the doctor-patient relationship.

I hope this information is helpful to you. If you have comments on the enclosed information, I would appreciate your sharing them with me.

Sincerely,

A handwritten signature in cursive script that reads "Robert S. Havely". The signature is written in dark ink and is positioned above the typed name.

Robert S. Havely
Health Issues Coordinator
National Issues and Policy

MARTIN E. GLASSER, M.D.
3241 SACRAMENTO STREET
SAN FRANCISCO, CALIFORNIA 94115
—
TELEPHONE S67-1142

September 2, 1976

Mr. Bob Havelly
Box 1976
Atlanta, Georgia 30301

Dear Mr. Havelly:

I am writing to you as a representative of a group of health professionals of Northern California who are in support of Governor Carter for President.

We represent a wide range of health professionals with a desire to assist in any way possible to educate our associates in order that they too will be actively supportive of Governor Carter.

Mary King's office suggested that we send our questions directly to you in order that they may be answered rapidly. We realize that some of these questions and issues have not as yet been fully explored, yet we hope you can share with us any relevant information that might help us.

I. Health Programs

- A. Does Governor Carter support a Health Plan or Health Insurance?
- B. Has he defined the limits of coverage, i.e., youth, adults, dentistry, mental health, etc.?
- C. Has he set criteria for which health professionals will be paid to deliver care?
- D. Would the delivery system be similar to a voucher system with freedom of choice or through a prepaid package?

II. Health Education

- A. Will there be provisions for prevention and education?
- B. What are Governor Carter's views on health education, drug education?

III. Abortion

- A. Has Governor Carter stated his views on the specifics of abortion?

September 2, 1976

IV. Health Administration

- A. Has Governor Carter specified how he will change the Federal Administrative structure viz a vis Health, H.E.W.?

V. Catastrophic Care

- A. How will routine health care be differentiated from catastrophic care, ie. chronic illness?

VI. Special Populations

- A. Will there be special provisions for children, adolescents, Senior citizens poverty level unemployed people?
- B. Does Governor Carter have mechanisms that will enable the Spanish-speaking consumer to provide input in those health issues directly related to their special needs, ie. migrant health care, maternal infant care, illegal alien health care?

VII. Educational Subsidies for Training Health Professionals

- A. What will be the provisions and subsidies for training health professionals viz a vis Third World people, medical schools, specialty training?

Thank you for your cooperation, we will be looking forward to your reply.

Sincerely,



Martin E. Glasser, M.D.

MEG:af

Blue Cross
Association



Walter J. McNerney
President

840 North Lake Shore Drive
Chicago, Illinois 60611
(312) 440-6010

July 19, 1976

Dear Mr. Carter:

I was gratified to read of your interest in preventive medicine because it is an interest I share as President of the Blue Cross Association, whose 69 member Plans serve the health care needs of 110 million -- or more than one out of every two -- Americans.

With health care costs now claiming \$118.5 billion annually, or 8.3 per cent of the gross national product, and likely to go much higher in the years to come, I believe that the time has come for us to realize that substantial improvements in our nation's health cannot be bought with the traditional approaches to health care now in effect.

Certainly, there can be no question that a national health insurance program would bring health care to more people. But, at the same time we must also take a broader view of health and a more realistic appraisal of what actually improves health status.

In effect, what we need is a new philosophy of health -- one that sees a man's health as a product of his total environment, his culture and life-styles, his earnings, education, housing and other such factors. Thus, if a better basic income or better environment, for example, would make for a healthier individual, it should be part of the nation's future health strategy.

For example, a current anomaly in our priorities is that we spend only \$134 million a year on research into the environmental causes of cancer, even though 80 per cent of all cancer is now thought to be environmentally related.

To explore the possible elements of a new national health strategy, the Blue Cross Association together with the Rockefeller Foundation and the University of California Health Policy Program recently co-sponsored a Conference on Future Directions in Health Care, which was attended by 140 key people representing every health discipline. I am enclosing a copy of the proceedings of the conference, the thrust of which is continuing through a small steering group which has since been meeting periodically to pursue the development of

the thoughts expressed at the conference. I am a member of this group which hopes to have a working paper ready for presentation at a future conference, possibly as early as this fall.

This activity represents only one of the Blue Cross organization's efforts in the area of new directions in health care. Another is our support of the National Center for Health Education, which grew out of the concepts developed by the President's Committee on Health Education, which I served as vice chairman. It would work in coordination with a governmental Institute for Health Information, Education and Promotion, as has been proposed in bills before the Congress. The Center has been incorporated to serve as a focal point for promoting, conducting and upgrading programs which educate citizens on maintaining their own health and the health of their families, including the proper use of health services and facilities.

For the reasons mentioned earlier, another area of increasing activity by the Blue Cross organization is environmental and occupational health. We are a backer of the Toxic Substance Bill which was recently passed by the Senate, and last August we and the AFL-CIO were among the sponsors of a multi-disciplinary Conference on Environmental Disease and National Health Policy. An interesting portion of our work in this area is a study being conducted at the Indiana Blue Cross Plan, under a grant from the Department of Labor, to help determine how Blue Cross Plan claims data can be used in identifying problems in occupational health.

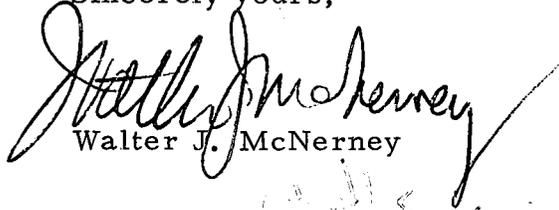
Several weeks ago, we announced a study we are undertaking to explore the feasibility of providing our subscribers with comprehensive treatment outside hospitals for alcoholism, the nation's fourth most common health problem after heart disease, cancer and mental illness. And in the near future, we plan to begin a similar study to determine the feasibility of offering our subscribers a cancer screening benefit. We are also encouraging hospitals to implement patient education programs through a new policy of reimbursing hospitals for such programs.

All this is not to say that the Blue Cross organization is not concerned with the problem of rising costs. To this end, the nation's Blue Cross Plans have implemented a number of cost control mechanisms including utilization review programs, incentive payment programs, support of areawide planning, alternative delivery systems, and benefit expansions. As a result, changes in utilization patterns have occurred among Blue Cross Plan subscribers. Inpatient days have decreased from 903 per 1,000 subscribers in 1970 to 826 in 1974 -- a drop of more than 8.5 per cent. Length of stay decreased from 7.32 days in 1969 to 6.74 in 1974. Today Blue Cross Plans pay twice as many claims for care received on an ambulatory basis as for admissions to a hospital bed.

The foregoing is meant to be only a brief summary of some of the new directions we are taking that are aimed at improving the well being of the more than half of all Americans who make up our subscribers.

I would be most happy to provide you with any more detailed information you would like that touch on our mutual interest in working toward a healthier America.

Sincerely yours,


Walter J. McNerney

Mr. Jimmy Carter
Plains, Georgia

WJM:gl

Mr. Walter J. McNerney
President, Blue Cross Association
840 North Lake Shore Drive
Chicago, Illinois 60611

Dear Mr. McNerney:

Thank you for your letter of July 19. 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.

I appreciate your thoughts and offer of advice. Any materials you wish to send would be most helpful. I am especially interested in the results of your studies on potential treatment methodologies for alcoholism.

Mary King is the leader of our health care task force, and she can be reached through our Washington office
(over)

please check on address
↓

at 1625 (7) Massachusetts Ave, NW, 20036 (2). May or
I would be delighted to hear ~~from~~ ^{from} you ^{on} matters
of concern, ~~to you~~ including National Health for or
deliberate system refo.

Thanks again for your interest in the Carter Campaign.

Sincerely,

Robert S. Haasly

National News + Pulse

Washington

1625 Mass. NW # 201

20036

1800 M' St. NW

20036

August 16, 1976

Mr. Walter J. McNerney
President
Blue Cross Association
840 North Lake Shore Drive
Chicago, Illinois 60611

Dear Mr. McNerney:

Thank you for your letter of July 19. 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 thoughts and offer of advice. Any materials you wish to send would be most helpful. I am especially interested in the results of your studies on potential treatment methodologies for alcoholism.

Mary King is the leader of our health care task force and she can be reached through: P. O. Box 1976, Atlanta, Ga. 30301.

Mary or I would be delighted to hear from you on further matters of concern, including National Health Insurance or delivery system reform.

Thanks again for your interest in the Carter campaign.

Sincerely,

Robert S. Havelly
National Issues and Policies

RSH:dan

FLOYD C. BRADLEY, D.D.
Pastor

First Baptist Church

400 Block on South Main
FLOYDADA, TEXAS 79235

June 17, 1976

Governor Jimmy Carter
State Capital
Atlanta, Georgia

Dear Mr. Carter,

I am writing to ask a simple question that many people have in our mind and heart. First, let me say that I am happy to have heard you mention your Christian faith and to know that you are a Southern Baptist.

Anyone knows the problems you face are many and complex. But I wonder what you will do at the Victory Celebration (if it comes), at White House Parties, etc. about drinking? If we could have a President who politely said "NO", I think it could have a profound effect for the moral uplift of our nation. Of course, my concern runs to many other moral issues, several of which I have already heard you publically express yourself.

I plan to encourage my people to pray for God's man to be elected to the presidency this November. I would be glad to report to them that Jimmy Carter will uphold every Christian virtue when elected.

I would deeply appreciate a simple answer to this letter.

May the Lord bless you and all those you hold dear in the days ahead.

Sincerely yours,



Floyd C. Bradley, Pastor

FCB/pd

August 16, 1976

Floyd C. Bradley
Pastor
First Baptist Church
400 Block on South Main
Floydada, Texas 79235

Dear Reverend Bradley:

② { 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

RSH; dan

FTON in White
Halls

August 16, 1976

Mrs. Richard Boyed
814 West Kibby Street
Lima, Ohio 45804

Dear Mrs. Boyed:

① { 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.~~

③ { 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

God Bless you.. Love you..
Keep you..

Lima, Ohio
July 30, 1976

Dear Mr. Carter,

I'm not sure if you'll ever see this letter, but I'm hoping you do - and will answer it.

I'm trying desperately to believe you really are a born-again Christian, and also a separated one. I am born again and try, with the help of my Saviour, to live a separated life. My life want and prayer, now is that my husband will accept Christ also. You must know how much everyone is watching you! My hubby sometimes ridiculed my beliefs and the "don'ts" in my life: "don't drink", "don't smoke,"

"don't swear", "don't dance", etc.

My question is this: How do you stand on these things? I read an article that stated you "danced with your wife" someplace, and one that infurred you and "the boys" celebrated. Would the White House still have it's cocktail parties, wine etc. if you were there? Would you still have balls, dances etc.? I was pleased when Gerald Ford just became Pres. and gave his "profession of faith". But then I was very disappointed when he laid like all the rest! In other words, I'd like to know how your personal life compares to that of our Lord.

My church has over 1500 in attendance. I intend to show my answer to my Pastor. He just told us he was confused as to how to vote this year. Our church is the Lima Baptist Temple.

Thank you! Mrs. Richard Boyd

Thanks for letter. Throw in

814 W. Kibbey St.

a couple of examples of how

Lima, Ohio 45804

religious he is. Believes moderate, decent Christian behavior is central to assisting in restoration & preservation of our values. DMM

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



Leaders, for a change.

October 4, 1976

Ms. Jean O'Leary
Co-Executive Director
National Gay Task Force
80 Fifth Avenue
New York, New York 10011

Dear Ms. O'Leary:

I enjoyed our conversation of last week. I am happy to review for you Governor Carter's position on gay rights.

The Governor has repeatedly expressed his opposition to all forms of discrimination, including discrimination based on sexual preference. He supports the principles of H.R. 5452 and will sign the bill if it reaches his desk. 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.

I hope this information is helpful. If you have further questions, please don't hesitate to call on me.

Sincerely,

Robert S. Havely
National Issues and Policy

The Medical Association of The State of Alabama

Nineteen South Jackson Street

Montgomery, Alabama 36104

*James L. Stallings
Director of Communications
And Public Relations*

June 21, 1976

Mr. Bob Haverly
P. O. Box 1976
Atlanta GA 30301

Dear Mr. Haverly:

Thank you for sending a copy of Governor Carter's speech before the Student National Medical Association. I have found it very informative and helpful in understanding Governor Carter's ideas on national health insurance.

You will find enclosed a copy of a letter I received from "who knows where" regarding the rumor that Ronald Reagan is a homosexual. I am sure that you have received copies of this, but I wanted to let you know that somebody is trying to damage Governor Carter's campaign in this way. I guess it takes all kinds, doesn't it?

Best regards,



James L. Stallings
Director of Communications
and Public Relations

JLS/ca

Enclosure

RECEIVED
JUN 7 1974
RECEIVED

Dear Editor;

I am writing to you in hopes of curbing a vicious rumor that is being spread by some on the Carter campaign that Ronald Reagan is a homosexual. Carter supporters say they have this documented and will cite such disreputable sources as a novelist who claims to have witnessed Mr. Reagan in a homosexual act, and articles written by the Los Angeles Free Press. Mr. Carter's recent statements to the press on the subject of homosexuality as "perversion" coincide with the spread of these rumors, and raise serious questions of integrity and political responsibility.

The Carter people make much of the fact that Mr. Reagan refused to take a lie detector test on the issue of his homosexual experiences--as if such refusal is demonstrative evidence that he is a homosexual. In any case the private life of any person should remain just that--private. We have evidence that other Presidents have had homosexual relations, but we feel it would not be acting responsibly to condemn a national leader on the basis of a few experiences earlier in life.

This letter is to inform you that Ronald Reagan is not a homosexual, and also to make it clear that the printing of any such allegations will render you actionable for libel. I'm sure that neither advertisers nor subscribers would want to associate with any paper that slanders a decent American like Mr. Reagan. I can assure you that you will find it in your own best interests to refrain from discrediting an honest candidate.

September 25, 1976

Manuel Vider, M.D.
517 Douglas Drive
Cherry Hill, N. J. 08034

Dear Dr. Vider:

Thank you for your letter of July 16. 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.

Governor Carter shares your concern for making medical care accessible as well as affordable for all our people. I am enclosing a copy of the Governor's remarks before the Student National Medical Association, in which he outlines his thoughts on delivery system reform, maldistribution, and National Health Insurance. After you look over the Governor's speech, you may have additional ideas or suggestions. I would be pleased to have your reaction to this material.

Thanks again for your interest and support.

Sincerely,

Robert S. Havely
Health Issues Coordinator
National Issues and Policy

RSJ:j

Enc.



TEMPLE UNIVERSITY
HEALTH SCIENCES CENTER
SCHOOL OF MEDICINE AND HOSPITAL
PHILADELPHIA, PENNSYLVANIA 19140

DEPARTMENT OF RADIOLOGY
SECTION OF RADIATION THERAPY

ROBERT ROBBINS, M.D.
MANUEL VIDER, M.D.

July 16, 1976

NATIONAL HEALTH INSURANCE

To: Mr. James E. Carter
From: Manuel Vider, M.D. *Mide*

The known health insurance systems in practice in this country as well as the nationalized systems in others, have as a common intrinsic deficiency, that,:

- 1.- The costs increase steadily due to the encouragement on the beneficiary to use the service.
- 2.- With the increase in costs and the complication in its management, it trend to increase the bureaucracy. A vicious circle develops, inviting violations, loopholes, decrease in efficiency, and so on.

Other deficiencies obvious of a huge management are consequences of these two.

In order to deal with providing a health service that is based both in insurance for the needed and is economically sounded, it could be:

- 1) Simple
- 2) Decentralized
- 3) Popular to its users
- 4) Economically controlled in its major part by the users themselves.
- 5) Exposed to the laws of the free market.

1) The simplest system, when large masses of people is involved is the decentralized (2) one, is also the most popular (3). How it is going to be controlled by the users themselves will be explained here.

A health insurance will be enacted by law, to be proportional to the income, and will be composed of two portions:

- A) A savings account to be managed by the user for 'planned' expenses. This portion will be around 80% of the tax.
- B) An insurance to cover the 'unplanned' expenses. This is the rest 20%.

The tax will be proportional to the income, and will be progressively increasing accordingly to its use. The 80% of his plan will be handled by the insured himself as a saving accounts for health and medical purposes only. An additional tax will be added just to the family that is actually using its savings, proportional to the withdrawals. For example: withdrawing of 25% will add 2.5% of the basic tax up to a maximum of around 10%. His savings will bear an additional 2% interest in order to encourage the saver. This portion of the insurance will be used freely by its owner and should be the first part that will be used before any application can be done to the other 20%.

This portion of the tax is reserved for 'unplanned' needs only and will be mana-

ged by the administration of the fund, on request of the medical facility. The administration of the insurance fund will deal with a budget that is approved in advance by the government.

People that live from gubermental support should be placed in the same savings-insurance program. The Medicaid program may function under the same guidelines. The population that live without gubermental support and have not fixed income and are not taxable will not posses the savings portion of the insurance, and will be covered for 'unplanned' expenses. The 20% of the tax will cover these people.

This system should work through the actual medical institutions that are accredited to give health and medical service. The insured will certify for the expenses that he incurr, up to the amount that appears in his saving assets. Any amount over that should be aproved by tha administration of the Health fund.

All providers certified to give service under this system should advertise in advance the extend and prices of the services. The insurer may request personally or may complain about any inaccuracies in information.

Anti-trust laws may regulate the prohibition of accords among institutions about charges and fees, to encourage competition.

Ethical and truthfull regulations may be enacted to protect the rights of the insured.

THE ADVANTAGES OF THIS SYSTEM:

The decentralization is the main mechanism that could bring succes to the whole program. It is not substituting a medical tax for a savings account. It is giving to the user the management of 80% (or whatever will be decided) of the tax itself in order to reduce bureaucracy, teach himself to manage efficiently collected tax money when his service is the subject of the tax. That portion of the decentralization is expected to exert tremendous economic pressure on the costs and on the efficiency. Psychologically, the population will get a real value of the dollar that he expends since any withdrawal authomatically increase his tax proportionally to the expense and subsequent savings decreases it. Additional incentives may be introduced for major savings.

The public will become self-confident on his government and its Treasury if he is given even that apparently small participation.

A PILOT STUDY

Since the system that I propose here is rather unusual in governmental businesses it should be tried in the comunity as a pilot study, through a special Grant from the National Institute of Health.

Before that, a small task force should be formed to discuss this with the public choiced for the pilot study, with fully participation of its representatives and Institutions, the press and the Health providers.

As the system itself, the pilot study should be simple in conception in order to succed.

WINNESHIEK COUNTY MEMORIAL HOSPITAL

DECORAH, IOWA 52101

319 - 382-2911

July 30, 1976

Governor Carter
Plains
Georgia 31780

Dear Governor Carter:

The enclosed comments illustrate the kind of problems we physicians continually contend with when encountering the federal regulatory bureaucracy. Nearly always the intent of congress is subverted by the anonymous individual who writes regulations.

Specifically, these regulations seem designed to divert all clinical laboratory business to large laboratories and to promote the employment of the highest paid classes of laboratory professionals.

These measures will most probably not improve the quality of clinical laboratory results, but they will certainly increase the already excessive clinical laboratory cost.

Very sincerely yours,



Hubert J. Van Peenen, M.D.
Pathologist

HJV/bw

WINNESHEIK COUNTY MEMORIAL HOSPITAL
DECORAH, IOWA 52101
319 - 382-2911

July 29, 1976

Office of Program Implementation
Office of the Assistant Secretary for Health
Room 17A-55 Parklawn Building
5600 Fishers Lane
Rocksville, Maryland 20852

Dear Sir:

The following comments apply to "Proposed Standards for Personnel in Clinical Laboratories", Federal Register vol. 41, no. 121, Tuesday June 22, 1976 which has just come to my attention.

Condition I

Paragraph a.2 - Requirement that the laboratory director of a 30 to 40 bed rural hospital performing a limited range of procedures be on premises 8 hours a week is excessive. Appropriate coverage can be done with 4 hours. Additional time would have to be filled with make-work. I recommend that the time on premises requirement be scaled to the laboratory work-load so that small hospitals are not burdened with excess costs for laboratory directorship. In rural areas there are not enough persons with director qualifications to provide this much on-site coverage. Remote institutions would be most unable to get coverage and would therefore be most vulnerable to loss of Medicare-Medicaid reimbursement.

Paragraph b.1 - Not all the professional board accreditations listed guarantee proficiency in general laboratory medicine. In particular doctoral level persons accredited in oral pathology, microbiology or cytology would probably be less proficient in other areas of the laboratory and less knowledgeable about the medical application of laboratory procedures than the technologists they direct. Condition II recognizes this problem but does not provide a logistically feasible remedy. Small laboratories cannot employ several Ph.D.'s, one for each of the laboratory disciplines.

Condition II

Paragraph a.4. It is entirely inappropriate that a technical supervisor who is in direct charge of procedures should be able to get by with as little as 4 hours on premises when the director, who is basically administrative, must be there 8 hours. See previous comment.

b-8 & 10. Master's level serologists and immunohematologists are not available in numbers enough to staff all large laboratories, much less all small ones. They are also much more expensive than bench technologists and at the transfusion service or routine serology level have no need for

their special skills. Blood-banking practice in the majority of small hospitals is very adequate today despite publicity to the contrary. Increasing personnel educational requirements will not solve the difficulties in the remainder.

b-13. The experience requirements are necessary only for those involved in in vitro testing or scanning. In vitro tests, especially radioimmunoassay, are bench level tests for which this requirement is excessive. If in vitro tests are not rigidly excluded from the scope of "radiobioassay" all easily performed inexpensive procedures such as digoxins and thyrosin assays will become the monopoly of diplomates of the American Board of Nuclear Medicine. This will increase the cost of procedures by decreasing the present healthy level of competition for them. The quality of the procedures are in no way improved by setting rigid personnel requirements for supervisors. This comment applies equally to other areas in the laboratory. Quality is best monitored and controlled by proficiency testing. If CLA personnel can do a test as well as master's level personnel or develop equally good supervisory skills they should not be prevented from doing the test or being promoted. The ultimate test of performance must be the quality of the laboratory result produced - its accuracy and precision.

Paragraph d-3. The requirement of 4 or more years experience for general supervisors is often unnecessary in small laboratories where fewer procedures need to be learned and fewer personnel dealt with. I have had very satisfactory supervising technologists who have had only one year of experience. This has been just as true in University Hospital laboratories as in those of the small hospitals I now serve.

Condition III

Paragraph b-7. It is imperative that the qualifying examinations be continued indefinitely. Otherwise a career advancement channel will be closed to many persons who develop competence through experience, but do not have college degrees. Many of these persons are from minority groups. The provision will unnecessarily discriminate against them. There is no good evidence that any educational requirement actually contributes to a better performance than does long experience. I have had good technologists with master's degrees and others with only a high school education. These comments also apply to paragraph e and f of Condition III.

Overall, the regulations seem designed to so increase the personnel costs of small rural hospitals and to so tightly specify the qualifications of their supervisors as to force them to close. This is certainly not the intent of the law or the secretary so they should be modified.

Office of Program Implementation

7-29-76

Page 3

I am pathologist to three small rural hospitals in Iowa. Before that I was in academic medicine for 13 years and directed laboratory sections and complete clinical laboratories of considerable size. My personal experience has been that personnel educational requirements are not the limiting factor in laboratory quality. Laboratories may be good or bad regardless of whether the majority of the technicians have bachelor's degrees and the supervisors doctorates. It would be far more useful in improving and guaranteeing laboratory quality to leave personnel selection to the individual laboratory and to monitor its product - the laboratory result - through more and better proficiency testing.

Very sincerely yours,



Hubert J. Van Peenen, M.D.

HJV/bw

September 25, 1976

Hubert J. Van Peenen, M.D.
Winneshiek County Memorial Hospital
Decorah, Iowa 52101

Dear Dr. Van Peenen:

Thank you for your letter of July 30. 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 concern about bureaucrats regulation and your comments about their effect on clinical laboratory cost. As you may know, Governor Carter has made reorganization and streamlining of government a major priority.

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

Sincerely,

Robert S. Havelly
Health Issues Coordinator
National Issues and Policy

RSH:j

Forward to 9-13-76
ATLANTA - PORTLAND, ORE,
Issues Dept.

MR. Jimmy CARTER
820 SW 4TH
PORTLAND, ORE. 97204

Navely

DEAR MR. CARTER.

I WILL MAKE THIS SHORT.

IN MY OPINION THE COUNTRY CAN
VERY WELL DO WITH OUT PUBLIC LAW
91-596 "OCCUPATIONAL SAFETY & HEALTH
ACT."

THE DIRECTOR, DR. MORTON CORN
IS OVER REACTING, LACKS COMMON
SENSE IN THE APPLICATION OF THE
STANDARDS, CREATING UNNECESSARY
HARDSHIP ON EVERYONE THEY TOUCH.

THE SAFETY OF INDUSTRIAL WORKERS,
IS BEST REGULATED BY STATE INDUSTRIAL
LAWS AS THEY APPLY IN EACH INDIVIDUAL
STATE, WHICH DIFFER FROM STATE TO STATE,

THE HEALTH DEPARTMENTS OF STATE
& COUNTY & EVEN CITIES CAN REGULATE
THIS AREA AS THEY HAVE FOR YEARS IN
THE PAST.

WE DON'T NEED OSHA NOR THE
EXPENSE THAT IS REQUIRED TO KEEP
IT IN OPERATION.

WHEN YOU BECOME PRESIDENT

WOULD YOU PLEASE ELIMINATE
THIS BRANCH OF BEAUCRATIC
CONTROL?

ALSO I AM SURE THAT IF YOU
WOULD DO A LITTLE SURVEYING
YOU WOULD FIND NEARLY 90%
OF THE PUBLIC AND BUSINESS
PEOPLE IN FAVOR OF "BANING"
THIS REGIMENTAL ACT FROM OUR
COUNTRY.

TRY THE USE OF THIS IN YOUR
CAMPAIGN TALKS - SEE WHAT
KIND OF REACTION YOU GET.

CORDIALLY YOURS.

O. Keith Diegel
8250 S.W. LEAHY RD,
PORTLAND, ORE 97225

September 25, 1976

Mr. O. Keith Diegel
8250 S. W. Leahy Road
Portland, Oregon 97225

Dear Mr. Diegel:

Governor Carter has referred your September 13 letter to me as I will be handling health care issues on the staff level during the campaign.

I appreciate your comments about the problems in the Occupational Safety and Health Administration. Governor Carter is committed to restoring professionalism to a streamlined and effective OSHA. I am enclosing for your review Governor Carter's position on this issue.

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

Sincerely,

Robert S. Havely
Health Issues Coordinator
National Issues and Policy

RSH:j

Enc.

August 20, 1976
Apartment 3
2153 Washington Avenue
Memphis, Tennessee 38104

Bob Harely
Carter-Mondale Campaign
P.O. Box 1976
Atlanta, Georgia

Dear Bob -

Since our phone conversation this afternoon I have considered several issues which I would like to develop further to send you. Among them, insurance coverage to back up policy regarding alcoholism (abuse, problems, etc.) for federal employees, and primary prevention of alcohol and drug problems are of great importance to many people. I hope to share my ideas on these and other concerns with you soon. I will at least get something to you.

If the extent of written input I can provide is sufficient I would hope you will not hesitate to discuss anything with me by phone.

I will be in touch with you further -

Sincerely -
Rick Barwick

BARWICK, HENRY R., JR.

EDUCATION

B. A.	1969	The Citadel	English, Psychology
	1971	University of Georgia Southeastern School of Alcohol Studies	
	1972	Washington University National Alcoholism Training Program for Professionals, Social Science Institute	
	1972	National Institute of Mental Health, Social Seminar Training Laboratory	
	1973	National Institute of Mental Health, Advanced Social Seminar Training Laboratory	

EXPERIENCE

Present

Assistant Director

Staff Trainer, Employee Assistance Program, Memphis, Tennessee.

Responsible for the design, development, delivery and evaluation of training programs for industrial supervisors, coordinators, management personnel and union shop stewards. This training is geared to enable industry to recognize work related problems as they reflect alcohol abuse, and to refer employees for assistance with these difficulties. In addition, is responsible for community education and coordination in regard to problems associated with alcohol abuse.

1975 - 1976

Free Lance Consultant, Washington, D. C.

Served as member of field teams in Los Angeles, San Francisco, San Diego, Chicago and Miami for the American Technical Assistance Corporation, McLean, Virginia. Collected and analyzed data on NIDA contract for the evaluation of Regional Drug Abuse Training Centers. Assisted in preparation of several proposals.

Served as Public Relations Consultant for George Mason University, Fairfax, Virginia, involving work on International Women's Year publication; Bicentennial Program; and a fund-raising brochure.

1975

United States Conference of Mayors, Washington, D. C.

Deputy Director, Alcohol Abuse Project. The project was funded by NIAAA to develop a network of city officials to deal effectively with prevention and treatment of alcohol abuse problems on the local level. As Deputy Director, responsibilities included collection of preliminary data from cities and formulation of initial policies by mayors. Specific activities: designed telephone questionnaires for mayors, city health officers, manpower planners and criminal justice planners in 80 cities throughout the U. S.; directed the activities of staff responsible for legal and funding analysis and technical assistance.

1971 - 1975

South Carolina Commission on Alcohol and Drug Abuse, Greenville, S. C.

Community Educational Representative. Assisted communities in organizing and implementing effective alcohol and drug abuse programs. Prepared annual reports, manuals, pamphlets, exhibits and displays. Developed and conducted training programs for public school teachers and administrators, public service agency staffs, church groups, civic organizations, business and industry, law enforcement personnel and government agencies. Coordinated and/or established Alcohol Safety Action Programs (ASAP) in 36 counties in the state. Established and maintained productive working relationships with newspapers, radio, and TV stations throughout the region. Designed and implemented programs for the prevention and early detection of alcohol and drug abuse for industrial groups in the region. Ex-officio member and acting Executive Director, Greenville County Commission on Alcohol and Drug Abuse. Acting Executive Director, Pickens County Commission on Alcohol and Drug Abuse.

1969 - 1971

Brookland-Cayce High School, Cayce, S. C. Physics and Chemistry Teacher.

Professional Associations

Palmetto Alumni Association of Southeastern School of Alcohol Studies
South Carolina State Employees' Association
Alcohol and Drug Problems Association of North America
International Council on Alcohol And Addictions

Other Activities

Consultant to Southeast Regional Training Center for Drug Abuse Education, University of Miami, 1973.
Paper presented: "Education As A Means of Prevention," South Carolina School of Alcohol and Drug Studies, University of South Carolina, 1974.

October 31

Bob

Governor:

Chip asked me to send any "medical" position papers we have to Dr. Hyman, to be included in a letter he is sending out. Steve Stark gave me the rather broad paper we have on health care, which I forwarded.

As you can see by the letter, Dr. Hyman feels the papers need revision. I thought you'd like to be aware of his ideas, since he will be calling Steve.

Frankie

WILLIAM HYMAN, M. D.

WILLIAM O. WILD, M. D.

ROGER A. SLATER, M. D.

Neurological Surgery

3505 LONG BEACH BOULEVARD

LONG BEACH, CALIFORNIA 90807

426-5567

AREA CODE 213

DIPLOMATES

THE AMERICAN BOARD OF NEUROLOGICAL SURGERY

A Medical Corporation

FELLOWS

AMERICAN COLLEGE OF SURGEONS

October 29, 1975

Mr. Steve Stark
Jimmy Carter Presidential Campaign
Post Office Box 1976
Atlanta, Georgia 30301

Dear Steve:

Maxie Wells forwarded to me some of Governor Jimmy Carter's position papers on health, which were involved in. She said you and he would welcome my input, and that you shall have, because I am on your side. However, the position papers need refining, both philosophically and pragmatically.

First, let me tell you a little bit about myself to establish my credibility with you. I am neither conservative nor liberal, as the labels go. I guess I am a middle roader — a moderate. I see problems and I try to solve them in a humane but detached way. I am not obsessed with squeezing out the last vestige of the "good life" in medicine, and protecting the medical establishment to the exclusion of the population that we are supposed to care for. I am not rich, and probably never will be. It is not a critical matter for me. I try to be a good doctor and take good care of the patients that are entrusted to me. And, I also think about bettering health care for all the people in the United States. I have a lot of degrees, a lot of honors, several pages of curriculum vitae — all of which are unimportant at this point.

What is important are some of my ideas on how we can improve health care in the United States. I don't know much about foreign affairs or business, but I do know about medical problems and people, because I have spent my 47 years learning about them.

I think we need national health insurance in this country, but we must be careful to avoid the pitfalls that have occurred in England and Sweden. There are many, many good features to the present health system in the United States, and there are also some injustices that have to be corrected. Mostly we need catastrophic health insurance to provide protection against the devastating illnesses that wipe out a family's financial resources

Mr. Steve Stark
Page 2, October 29, 1975

because of the prolonged nature of the disease. We must try to preserve the traditional doctor-patient relationship, so that a patient doesn't become just another number, and so that a doctor remains motivated to care for that patient on a personal basis. Fee-for-service is a good concept, providing the fees are reasonable and I favor this approach. People should not expect something for nothing. That only breeds laziness and abuse of the system. Research is to be encouraged, because therein lies the best chance for preventive medicine. HMOs may work in some instances, but this country is too diverse, too heterogenous, to mandate HMOs for everyone, everywhere. It won't wash, and if you stuff it down everyone's throat too quickly, you will suffer the vomitus and the backlash. Do not commit this nation to a sudden expensive medical path that becomes irretrievable. Build with thought and imagination — and with care. And try to build some freedom and flexibility into the new system, that encourages and rewards creativeness among medical personnel. Capitalism is a good system. It has worked well for us. But it has to be capitalism with a social conscience. We live in an imperfect world, but we have an obligation to make it a better one. There are a lot of us who want to help.

Sincerely yours,

William Hyman, M.D.
President
Long Beach Medical Association

WH/vb

cc: Ms. Maxie Wells
Francis Hertzog, Jr., M.D.

99 WILLIAM STREET
NEW YORK, NEW YORK 10038
(212) 425-3300
CABLE ADDRESSES: "PROBATICA" OR "ELEFAR"

September 1, 1976

Mr. Robert S. Havely
National Issues and Policy
Jimmy Carter's Presidential Campaign
P. O. Box 1976
Atlanta, GA 30301

Dear Mr. Havely:

Thank you for your letter of August 18. I have read Governor Carter's speech with great interest and indeed have several comments regarding it.

First, as a general statement, there is little that I, as an individual, can disagree with. The Governor's approach, as outlined in his speech, is reasonable, logical, and very humane.

Second, several key points were discussed in the speech, i.e., accessibility, health prevention, and health planning. All these factors are important, but must be perceived as only part of a total problem, not individually.

Third, the Governor mentioned, but did not detail, his plans for reimbursement of a National Health Insurance (NHI) program. I believe it is critically important that you recognize that the financial mechanism will be a keystone to your plan. Have you analyzed the impact your NHI plan could have on the different parties involved and looked at other alternatives? Obviously, the financial impact will be felt by all of the parties involved:

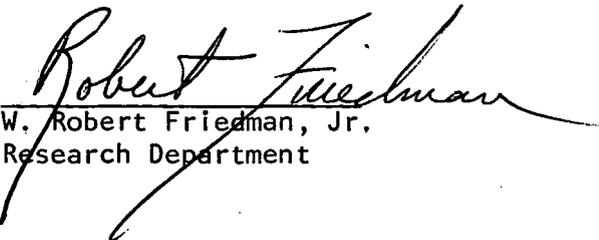
- (A) The Individual Taxpayer. What impact will your NHI funding policy have on disposable income, especially if concurrent to the implementation of higher payroll taxes, social security payments also increase? What are your plans for social security taxes under NHI? Can the individual afford to pay for both, without seriously impacting his purchasing for other goods/services?
- (B) The Business Entity. What impact would your financing mechanism have on the profitability of the smaller companies? We can see the impact health care benefits are having on companies the size of General Motors. Will NHI payments be tax deductible? One can hypothesize that over the short-term, NHI payments will represent a non-productive cost impacting a company's productivity, while, no doubt, over the longer term, the program should increase productivity, assuming fewer people are sick.
- (C) The Country. What impact will your plan have on the nation's resources; will you have to increase taxes to meet other social, economic, and military needs?

Fourth, in his speech, the Governor briefly mentioned the need for establishing priorities, but did not discuss a mechanism for implementing such a review. One can easily see that, had we established a logical plan for the implementation of Medicare in 1965, perhaps the current health inflation could have been afforded.

In my opinion, it is extremely important that you and your staff establish a detailed plan for implementing your NHI program. Only if this action is taken, will you stand a chance of being able to control the inflation factor. May I suggest you reference the plan suggested by Dean Wilbur Cohen, former Secretary of HEW, and currently Dean of the University of Michigan's School of Education. Dean Cohen proposed a detailed implementation plan, spanning several years, while testifying before a Congressional committee. I am sure Dean Cohen would be more than pleased to discuss his ideas with you.

I hope these comments have been helpful. I look forward to meeting you to discuss your perception of our health care system. Should you be coming East any time in the near future, please call so we can get together for drinks. Should I be coming to Atlanta within the next several weeks, I would very much like the opportunity to meet with you.

Sincerely,


W. Robert Friedman, Jr.
Research Department

WRF:mf

BOB, CARE
HEALTH CARE
I THINK YOU
SHOULD GIVE
THIS GUY A
CALL.

May 10, 1976

OR WRITE

Edward L. Gilbert, M.D.

2901 WEST OLIVE AVENUE
BURBANK, CALIFORNIA 91505

TELEPHONE 845-2631

Mike Miller
Jimmy Carter Presidential Campaign
Southern California Headquarters
8727 W. Third Street, Suite 203
Los Angeles, California 90048

RE: National Health Plan

Dear Mr. Miller;

I have recently been in contact with you and Supervisor Edelman concerning my ideas about National Health Plan. I have been working on this subject and doing research for many years. I have spent sometime with a Congressman as we as other interested parties. It would be impossible to outline my conclusions in a short letter. However, I will try to present some salient features to you. Hopefully this will enable me to eventually sit down and talk with someone in your Issues Department about the facts I have accumulated. The following points might catch your eye.

First there is a great problem confusing the delivery of medical care with the cost of medical care and most politicians are trying to solve the cost problem by changing the delivery system. I feel this is an obvious mistake and that the present system of delivery can be improved without destroying it. My basic concept is the primary care physicians as opposed to health maintenance organizations. However, both will remain as viable systems in the future. Supporting HMO'S really encourages the businessman and the charlatons. If we promote primary care physicians we can eliminate most of the unnecessary expense in medicine.

The next point that should be examined is exactly where increased medical costs come from and how to deal with some of the problems immediately. I feel that most increases in medical expense is due to defensive medicine. Unnecessary studies and hospitalization as well as mal practice insurance have probably doubled the cost of medical care in the past few years. I feel that quality control could be handled

Edward L. Gilbert, M.D.

2901 WEST OLIVE AVENUE
BURBANK, CALIFORNIA 91505

TELEPHONE 845-2631

without these unnecessary span es, if primary physicians followed their patients into the hospital and worked along with the specialists, the primary physician would have no financial interest in expensive prodedures, but would have an interest in the patient. He could be considered their "medical advocate".

The next point deals with shortage of medical persomel. I beleive there are too many specialists and too few general practioners -- anyone can tell you that. Solving this problem appears obvious, but most politicians are pushing for paramedics and large clinics instead of increasing the supply of primary care physicians.

To give you a simple analogy of what I propose, just think of a family. The parents continue to take an interest in the child no matter what problems occur. He is never sent to another family because of health, financial or legal difficulties. A primary care physician usually has the same relationship with his patients regardless of the specialized medical problem. I propose keeping the present Doctor/patient relationship and not turning the patient into a chart or an IBM card. My ideas are certainly not new and I have many statistics to prove it is cheaper to see the family physician than to go to the clinics.

Please give me the opportunity to present the facts I have gathered to someone in the Carter campaign who is knowledgeable in this field.

The catch phrase could be, "Everyone is entitled to a family doctor who will be both physician and medical advocate".

Sincerely Yours,



Edward L. Gilbert, M.D.
ELG/bjw

Edward L. Gilbert, M.D.

2901 WEST OLIVE AVENUE
BURBANK, CALIFORNIA 91505

TELEPHONE 845-2631

May 19, 1976

Bob Havelly
Issues Staff
Carter Campaign
P.O. Box 1976
Atlanta, Ga. 30301

Dear Mr. Havelly;

I believe by now you have read my two previous letters concerning National Health Plans. This letter is simply a follow-up to clarify the four points in the last letter.

Point number one - Catastrophic Insurance - \$5,000 annual deductible.

I would suggest a \$10,000 five year deductible in addition to the \$5,000 annual deductible.

Many people with insurance do not realize that their insurance only pays \$15,000-\$20,000 maximum. Catastrophic insurance is essential for any National Health Plan. The net cost to the government would be small since most people never have \$5,000 medical bills.

Point number two - Medical Fees.

I believe most doctors charge too little for most of their services. The reason doctors make large incomes has to do with what I call "gimmicks". Most of their gimmicks are ethical but I believe the charges are not appropriate for the services. Doctors charge too little for their usual office visits, telephone calls, and hospital care; they charge inappropriately high fees for surgical procedures, laboratory work, x-rays, etc. This system would change when expensive procedures are at a scheduled rate as I suggested. The net gain would be less expensive medical care but people should be prepared for a rise in routine fees until more physicians are available.

Point number three - Personal Physicians - Medical Advocate Concept.

This should not be a mandatory program; both doctors and patients should remain free to choose their doctor/patient relationship. The money paid for following a patient should be small. It should only encourage primary care physicians but should not

Edward L. Gilbert, M.D.

2901 WEST OLIVE AVENUE
BURBANK, CALIFORNIA 91505

TELEPHONE 845-2631

interfer with usual fees and should certainly not encourage high paid, well trained specialists to do primary care.

Point number four - Producing more Primary Care Physicians.

It is a disgrace that about one third of M.D.'s recently licensed in the United States are foreign trained when we have such well qualified American students. An article in the American Medical Journal of last year shows these statistics. The way to remedy this is obvious.

Less government control means better quality. It is the doctor who keeps up on medical research that is the leader in a community. He should be encouraged to use the most modern approved procedures, medications, and equipment. If we do "cook book" medicine as many government officials suggest, we will certainly stifle medical progress which is so necessary to our profession.

Private fees will always remain at half the clinic or county hospital charges since private office overhead is always less.

I hope now I will be able to continue my dialogue with someone in the Carter staff, in person.

Sincerely Yours,

Edward L. Gilbert, M.D.

Edward L. Gilbert, M.D.

ELG/bjw

Edward L. Gilbert, M.D.

2901 WEST OLIVE AVENUE
BURBANK, CALIFORNIA 91505

TELEPHONE 845-2631

May 14, 1976

Bob Havelly
Issues Staff
Carter Campaign
P.O. Box 1976
Atlanta, Ga. 30301

Dear Mr. Havelly;

Thank you for your phone call and interest in my ideas concerning National Health Plans. I hope my qualifications and reliability have been verified by now so an attentive evaluation will be given to the following specific ideas:

1. Catastrophic health insurance mandatory for all, paid through general tax funds. This should be about a \$5,000.00 annual deductible per family unit based on IRS household groups.

The lower income people could still have a form of medic-aid, and the rest of the people could continue to either buy supplemental insurance or go without further insurance. This plan would not interfere greatly with insurance companies, and the average family would be assured that medical bills could not "wipe them out".

2. Large medical fees and costs should be regulated by the government. For example, all hospital fees and any procedures which cost over \$500.00 would be standardized for a community.

The office visits and even most hospital care by physicians would remain a free market but the costly procedures would have a pre determined price tag. This particular point is predicated on more general practitioners which is, of course, my major proposal.

3. Every individual in the United States should have the opportunity to sign up with an M.D. to be his personal physician. This specific named doctor would follow the patient both in and out of the hospital no matter what specialist was consulted or even if the patient was in the Mayo Clinic. The consulting physicians would send reports to the named doctor, so the patient and family would always have a medically

Edward L. Gilbert, M.D.

2901 WEST OLIVE AVENUE
BURBANK, CALIFORNIA 91505

TELEPHONE 845-2631

knowledgeable advocate with whom to discuss all medical problems.

This personal physician would be the "medical advocate". He would be the monitoring force for specialized care and would prevent duplication of services. He could make sure specialized care was given quickly when urgently needed.

Any patient would retain the right to go to any specialist directly at anytime and could choose not to have a personal physician. However, the patient is then risking this charge being disallowed toward government guaranteed insurance.

Their personal physician ("medical advocate") would be paid by the government for this service. I suggest about \$1.00 per patient per month. This could go up by \$.10 each year as patient stays with the same doctor. If a doctor continues to be the family physician in the above stated capacity for say 20 years, he needs only one-third as many patients to receive the same compensation from the government as a new generalist. This would be quite an inducement to be a general physician and keep semi-retired doctors active. This plan would also suddenly give more status to primary care physicians in the community.

4. We must produce more primary care physicians if the above plan is to work. We must also get these physicians into the right areas, such as urban ghettos and remote rural areas.

This could be done in two ways. One is to encourage medical schools to produce more family doctors -- this has already been started. The other way is to give financial aid to starting physicians if they promise to remain in certain designated areas as primary care physicians for 2 or 3 years.

I do not believe there is a shortage of doctors, only a mal-distribution both as to areas and speciality. If money is put into producing more qualified primary care physicians, then less will have to be put towards allied fields. Patients will be seen first by M.D.'s. No screening; no waiting in line; and the patient is treated as an individual and not a chart or an IBM card.

For a more detailed explanation of my ideas and research please give me the opportunity to talk directly with you. I also have specific thoughts concerning quality control, malpractice insurance, etc., but these are mainly state problems and you may not need that information at this time.

Sincerely Yours,



Edward L. Gilbert, M.D.

Edward L. Gilbert, M.D.

2901 WEST OLIVE AVENUE
BURBANK, CALIFORNIA 91505

TELEPHONE 845-2631

June 15, 1976

Mr. Bob Havelly
c/o Carter Campaign
Issues Staff
P.O. Box 1976
Atlanta, Ga 30301

Dear Mr. Havelly;

Enclosed is an outline of my complete National Health Plan, as you requested in our phone conversation on Friday, June 11th.

Sincerely Yours,

Edward L. Gilbert, M.D.

Edward L. Gilbert, M.D.

Edward L. Gilbert, M.D.

2901 WEST OLIVE AVENUE
BURBANK, CALIFORNIA 91505

TELEPHONE 845-2631

THE PERSONAL PHYSICIAN, A "MEDICAL ADVOCATE",
AS A BASIS FOR A NATIONAL HEALTH PLAN

by

Edward L. Gilbert, M.D.

Edward L. Gilbert, M.D.

2901 WEST OLIVE AVENUE
BURBANK, CALIFORNIA 91505

TELEPHONE 845-2631

The Personal Physician, a "medical advocate", as a Basis for a National Health Plan

Purpose: To show that primary care physicians can give immediate, quality medical care to everyone in the United States at a reasonable price without disruption of our present system.

- I. Definition of personal physician, a "medical advocate"
- II. Basic goals of National Health care which coincide with this system
- III. Historical precedents for this concept
- IV. Implementation of the system
- V. The advantages of this system
- VI. Comparing alternative plans for health care---particularly Health Maintenance Organizations
- VII. Our present medical system---costs and delivery
- VIII. Producing and distributing more primary care physicians
- IX. Control of fees and expenses
- X. Universal government insurance
- XI. Continuing education and quality control

I. Definition of personal physician, a "medical advocate"

Every individual in the United States would have the opportunity to sign up with an M.D. to be his personal physician. The specific named doctor would follow and be responsible for the patient both in and out of the hospital no matter what specialist was consulted or even if the patient were in the Mayo Clinic. The consulting physicians would be required to send reports to the named doctor, so the patient and family would always have a medically knowledgeable advocate with whom to discuss all medical problems. This physician would be the monitoring force for specialized care and would prevent duplication or unnecessary services. He could make sure specialized care was given quickly when urgently needed.

II. Basic goals of national health care which coincide with the personal physician -- "medical advocate" concept:

1. Increase the number of primary care physicians.
2. Encourage primary care physicians to practice in rural areas and urban ghettos.
3. Have qualified physicians responsible for total medical care of patients.
4. Upgrade the quality of primary care physicians and their status in both the medical and general community.
5. Reduce time from occurrence of illness or injury to time of definitive care.
6. Reduce medical expenses.
7. Treat patients as individuals and not charts or IBM cards.
8. Maintain close doctor patient relationships.
9. Eliminate unnecessary services.
10. Eliminate duplication of services.
11. Reduce paper work and "red tape".
12. Eliminate need for numerous allied health personnel.
13. Eliminate need for many medical specialists.
14. Eliminate need for new complex organizations such as Health Maintenance Organizations.
15. Alleviate the malpractice insurance problem.
16. Minimize government controls.
17. Remove many poor from the government medical aid programs.
18. Induce patients to choose primary care physicians instead of specialists for most care.
19. Educate patients.

III. Historical precedents for personal physician---"medical advocate" system.

- A. Up to recent times, most people had one physician who took care of all medical problems. As medicine became more complex, specialized medical care and more highly trained physicians became a part of the system. This system became increasingly expensive and disjointed.
 - 1. In most urban areas there developed a double standard of medical care.
 - a. Some people go from specialist to specialist with their common medical ailments and use the larger, well-equipped hospitals. There are no family doctors allowed on the staffs of these large hospitals.
 - b. Meanwhile, other people less well-to-do or who desire a more personalized type of care go to general practitioners who may or may not be well trained. These doctors practice in smaller hospitals without all the latest equipment or expert consultants.
 - 2. However, in most suburban and other areas of the United States there is a balance of primary care physicians and specialists. This system, where specialists are used properly and primary care physicians dominate the picture, appears to work well and expenses are less than in urban areas with quality being uniformly high. Nevertheless, expenses are above what many middle class workers can afford.
- B. In order to solve the cost problem, various changes have been made in socialized medical systems which confuse the cost problem with the delivery of medical care. Most of these changes have increased the bureaucracy and the overall cost while destroying the delivery system.
 - 1. One innovation in England which has had some success in monitoring medical care is the panel system where people sign up with a specific primary care physician. This system, however, shifts the care of the seriously ill patient to the hospital-based physicians, and this is where the continuity and quality of medical care break down.
- C. With the use of a panel type system and the proper balance of specialists, as is now present in much of the country, we can prevent both total socialized medicine as in England and avoid the present problem of dual standards of medical care as in large, urban areas.

IV. Implementation of this medical system.

- A. A patient or family would sign up each year with an M.D. to be his personal physician. This specific named physician would be the personal physician or "medical advocate" for the patients he wished to accept.
 - 1. The physician would be responsible for total medical care both in and out of the hospital.
 - 2. He would be the monitoring force for specialized care by obtaining such care and preventing unnecessary care.
- B. Any patient would retain the right to go to any specialist directly at any time and could choose not to have a personal physician. However, the patient is then risking his medical bills being disallowed by whatever type of government guaranteed insurance is in use.
 - 1. The program should not be mandatory. Both doctors and patients should be free to choose their doctor/patient relationship.
 - 2. Patients belonging to medical groups would also have a member physician of that group as his personal physician. Even county Hospital patients will be assigned a staff physician to take responsibility.

C. The personal physician should be paid by the government for the service of following a patient.

1. The fee paid for following a patient should be small. It should encourage primary care physicians but should not interfere with usual fees and should not encourage the highly paid, well trained specialists to do primary care.
2. About \$1.00 per patient per month would be appropriate.
3. This initial fee would increase by \$.10 each year as the patient stays with the same doctor. If a doctor continues to be the family physician in the above capacity for 20 years, he would need only one-third as many patients for the same compensation from the government as a new general practitioner.

V. Advantages of this system:

1. The patient will have a medically knowledgeable advocate to consult with at all times.
 - a. The physician will know the patient personally and have all his medical records.
 - b. All routine medical care will be handled by the one doctor, and urgent specialized care will be obtained without delay.
2. The specialists will be responsible to both the patient and to the personal physician.
 - a. If various specialists are necessary, the personal physician can coordinate the care, and the family will have someone they know with whom to discuss the medical problems.
 - b. There may be an overlap but never a lack or gap in medical responsibility.
3. Many people now use emergency rooms for routine medical care because they have not established themselves with a family doctor and have nowhere else to go.
 - a. With a personal physician the patient would always have someone to call.
 - b. Even if another doctor were on call for the specific named doctor, at least a qualified M.D. would immediately accept the responsibility for medical care.
4. There would be more status for the primary care physician in the community.
5. Semi-retired doctors would be induced to remain active.
6. The primary physician would have little if any financial interest in expensive procedures and surgery but would be solely interested in care of the patient.
7. Quality control and re-education of primary care physicians could be uniform throughout the country.
 - a. Concurrently the specialist who keeps up on medical research will be encouraged to remain a leader in the community.
 - b. If specialists use the most modern equipment, procedures, and medications, the primary physician is in the best position to recognize this asset and take advantage of it.
8. When there are more primary care physicians and they are subsidized by the government, the fees will be lower.
 - a. The income from the government will drastically reduce charges to patients.
 - b. Certainly there will be competition on the free market for patients.
9. The government will be in a better position to be aware of charlatans.
 - a. Large health care organizations may monitor themselves but can also hide poor care and over utilization.
 - b. An individual physician who is not performing properly will be more obvious.

10. There will be a reduction in malpractice suits since the personal physician is always directly involved with the care given.
 - a. Most suits are the result of misunderstanding and personality problems rather than actual malpractice. This type of situation will be avoided.
11. Many people will leave the government aid programs and seek private practitioners.
 - a. Lower fees.
 - b. Willing doctors since these patients can be treated like all others without special "red tape".
12. The large differential in fees will induce patients to seek primary care physicians instead of specialists when the primary care physician is subsidized.
13. Money paid by the government for health care will no longer go first to an intermediary such as an H M O, insurance company, or the patient. Direct subsidy to the doctor is feasible.
14. Patient education improves the outcome of the disease.
 - a. Patients accept serious illness realistically.
 - b. They deal with their problems more effectively.

VI. Alternative plans of health care compared with this system-- Particularly Health Maintenance Organizations..

A. Free medical care

The founder of the Kaiser Permanente system, Dr. Sidney Garfield admitted, "... that the elimination of the fee is practically as much a barrier to early sick care as the fee itself. The reason is that when we remove the fee, we remove the regulator of flow into the system and put nothing in its place..."

1. Direct payment is an excellent means of cost control for routine type medical care.

a. The doctor knowing that the patient is paying is a force to influence lower bills.

b. Consider free food in a supermarket or free clothing from a department store since these are also basic human needs. The system breaks down if there is no monitoring force.

2. The only alternative to fee for service as a force to limit over utilization is some type of screening and most people would prefer direct payment if it were within their means.

B. Health Maintenance Organizations will remain a viable system for the future but it has the following faults compared with the personal physician system:

1. Government money encourages charlatans and businessmen to exploit the doctor and the system--many such scandals have been exposed.

2. With the cost of maintaining large clinic facilities and salaries of secretaries and allied medical personnel, the actual overhead per patient visit is greater than in a private practitioner's office.

3. Long waits to see physicians are standard.

4. Screening of patient by para-medical personnel is common.

5. Two simple unrelated medical problems often require separate appointments with different doctors.

6. Most care is impersonal, and in emergencies no attempt is made to contact a physician who is personally acquainted with the patient---to a patient in coma or shock this is important.

7. Physicians may not order necessary expensive studies since their personal income may be diminished.

8. Often there is a lack of privacy during examinations.
9. Regular office hours and telephone calls are not in response to patients needs.
10. All physicians are put on full schedules and have little time to consult with other physicians.
11. A doctor does not follow a patient he refers to another department, and the consultant is not obligated to the referring physician. to explain care.
12. The patient literally becomes a chart and not an individual. If the chart is misplaced, the patient has more than a medical problem.
13. The key word in HMO's is preventive medicine and yet many subscribers use private practitioners for annual physicals. Forty-four percent of Kaiser-Permenente members have seen private doctors while members of that plan. This statistic is from Kaiser's own interviews and could be even higher.
14. Elective surgery is often postponed since there is usually a shortage of hospital beds. The Kaiser Hospitals often run over 100% occupancy. This policy is a dangerous cost cutter.

C. Other socialized systems

1. In England the system is under financed so it is not a good example, but one statistic is significant. Infant mortality is 50% higher in lower social classes than in the higher social classes. Factors other than health care systems influence most medical statistics.
2. In Sweden the system is well financed and the people are all in a similar socio-economic group. However, they too have a well documented "health care crisis" with a shortage of medical facilities.
 - a. The people complain about the impersonal care and long waits, etc.
 - b. As in England and the Soviet Union some people must wait up to two years for elective surgery.
 - c. In England and Sweden private practice is a very viable alternative and the governments try to restrict this competition.
 - d. The tax burden to pay for these systems is another common complaint of their citizens.

VII. Our present system--costs and delivery

- A. The cost of medical care is generally too expensive for these reasons:
 1. Defensive medicine--unnecessary referrals, hospitalization and expensive studies are done to protect against law suits.
 2. Duplication of services; referrals without records, and patients not fully trusting impersonal specialists.
 3. New costly procedures and equipment.
 4. Salaries of allied health personnel are rising rapidly.
- B. Doctors make a good living but actually charge too little for most of their services. Large incomes for doctors come from "gimmicks". Most of their gimmicks are ethical but the charges are inappropriate for the service.
 1. Doctors charge too little for their usual office visits, telephone calls and hospital care.
 2. They charge inappropriate high fees for surgical procedures, laboratory work, x-rays, etc.
- C. Delivery of care is different for the wealthy, middle class and poor.
 1. The wealthy usually have an internist or pediatrician as a primary care physician who does act as an efficient "medical advocate" and obtains specialized care quickly. However, this physician is not qualified to give routine medical care such as suturing a simple

lateration or treating a simple fracture. The internist does not assist in surgery and often does not even follow patients referred for surgery.

2. The middle class patient usually has a family doctor or is enrolled in an HMO. Generally he gets prompt good quality medical care at a reasonable price. However, his medical insurance bills are usually one of his biggest expenses and if the rare catastrophe does occur, he can be financially ruined.

3. The poor receive good medical care on most government aid programs, but the delivery is slow except for emergency situations. They have to wait in long lines for routine care and have the same complaints as HMO participants only more so: The surroundings are not pleasant, the doctors are more rushed and impersonal, etc. There is a definite shortage of personnel and facilities in many poverty areas.

V

VIII. Producing and distributing more primary care physicians.

- A. Producing more primary care physicians is basically a function of the state supported medical schools.
1. Grants should be given to medical schools that have programs which emphasize family practice.
 2. Federal grants can also be given to hospitals with approved family practice training programs.
- B. Distribution of primary care physicians.
1. Loans or grants could be given by the state or federal government in return for a contract guaranteeing a primary care physician will practice in a particular rural area or urban ghetto for 2 or 3 years.
 2. Increase in incentive pay for personal physician--"medical advocate" could be greater in certain areas.
 - a. For example a starting fee of \$1.20 per patient per month in rural areas and \$1.30 in certain urban ghettos.
 - b. In these areas there will be a legal maximum number of patients a physician can accept.

IX. Control of fees and expenses

- A. Control of hospital and expensive procedure costs.
1. These can be regulated as to procedure done and geographic area when they are expensive.
 2. Hospital charges and procedures which are in excess of \$500 or even \$1,000 should be on a government controlled schedule.
- B. Doctors' fees should remain an open market except for very expensive surgery or procedures.
1. This encourages competition.
 2. This reduces government paper work of controlling agencies for minimal fees.
 3. Expensive procedures such as heart operations which are in excess of the \$500 or \$1,000 minimum will be on a government schedule.
- C. Eliminate non-professional doctor charges.
1. No routine or non-urgent laboratory work should be done in doctors offices for more than local laboratory charges.
 2. Separate professional fee from actual technician and procedural expense for such things as x-rays and electrocardiograms.

X. Universal government insurance

- A. Initially the government can only afford catastrophic insurance.
 - 1. Mandatory insurance for all people.
 - 2. About a \$5,000 annual deductible per family unit based on IRS household groups.
 - 3. A total \$10,000 five year deductible in addition to the annual \$5,000.
- B. Advantages of this type of catastrophic insurance.
 - 1. Poverty patients would still have some medical aid program.
 - 2. The rest of the people could either buy supplemental insurance or go without.
 - a. Insurance companies would continue in some capacity.
 - b. The average family would be assured that medical bills could not "wipe them out".
 - 3. The actual net cost and personnel required to run this insurance program would be small since most people never have \$5,000 medical bills in one year.

XI. Continuing education and quality control of primary physicians.

- A. All primary care physicians will be required to participate in a continuing education program.
 - 1. Approximately every seven years a primary physician must spend one month in a recognized teaching hospital training program.
 - 2. The training should be like an intern or resident with only in-patient responsibilities--clinic training would be superfluous.
- B. The appropriate time for this training would be the last two weeks in June and the first two weeks in July.
 - 1. This would overlap with the change over period in teaching hospitals.
 - 2. The doctor would initially brush up and learn from outgoing young residents.
 - 3. The doctor would then assist with training of the new interns and residents.
 - 4. The patient care in these teaching hospitals would not suffer as it now does annually at that time of year.
- C. Examinations could be given at the end of each training period for basic medical skills.

Edward L. Gilbert, M.D.

2901 WEST OLIVE AVENUE
BURBANK, CALIFORNIA 91505

TELEPHONE 845-2631

June 16, 1976

Bob Havely
c/o Carter Campaign
Issues Staff
P.O. Box 1976
Atlanta, Ga. 30301

Dear Mr. Havely;

One point I may not have made clear should be brought to your attention.

Although my plan is based on research all the ideas presented are totally original. This may be important when presenting this concept to policy makers.

Sincerely Yours,



Edward L. Gilbert, M.D.
ELG/bjw

Edward L. Gilbert, M.D.

2901 WEST OLIVE AVENUE
BURBANK, CALIFORNIA 91505

TELEPHONE 845-2631

June 18, 1976

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

Dear Mr. Havelly;

I hope the outline was brief and explicit enough for you to get a full understanding of my basic health plan.

There are many questions and problems which will arise and I would like to answer them personally, However, since that is not practical at this time I will just answer some of the obvious questions that you may have.

1. Most people (about 90%) now have some form of insurance through work, unions, or private. I do not wish to disrupt this, but only make it cheaper since their policies will now be \$5,000 maximum.
2. Poor people on aid programs will still go to County Hospitals and clinics. They can have a private physician if they wish and still be referred to County Hospitals under seriously ill conditions. If they choose this, they will have the private physician for follow up care and he will get all information from the hospital.
3. Low, but not poverty, economic groups may be assigned a lower maximum catastrophic insurance rate by the social service workers. Possibly a \$1,000 annual maximum. I believe all people ought to be obligated to pay something and make their own arrangements just as if they suddenly needed a new refrigerator or car. However, health providers could be asked to accept some type of installment in special cases.
4. Patients that can afford care but that no doctor wishes to accept for whatever reason will be allotted as "assigned risks" to doctors. The mal-practice insurance covering those particular patients will be carried by the government.

Sincerely Yours,

Edward L. Gilbert

Edward L. Gilbert, M.D.
ELG/bjw

Edward L. Gilbert, M.D.

2901 WEST OLIVE AVENUE
BURBANK, CALIFORNIA 91505

TELEPHONE 845-2631

June 24, 1976

Bob Havely
Issues Staff
Carter Campaign
P.O. Box 1976
Atlanta, Ga. 30301

Dear Mr. Havely,

When the health plan is submitted to physicians for evaluations, the fee schedule will be scrutinized first.

The expensive procedure fee schedule is only applicable when the government catastrophic insurance is used. Fees in excess of the schedule may be charged and collected from insurance companies or patients by medical providers as long as the government catastrophic co-insurance is not utilized.

This will keep government monitoring minimal and manageable. It will allow all health providers to continue their usual fees in most cases.

Sincerely Yours,

Edward L. Gilbert, M.D.

Edward L. Gilbert, M.D.

ELG/bjw

EQUIFAX

Information for Business Decisions

Equifax Inc.

Post Office Box 4081
Atlanta, Georgia 30302

W. Lee Burge, President

May 20, 1976

Governor Jimmy Carter
Carter Campaign Headquarters
1789 Peachtree Rd., N. E.
Atlanta, Georgia

Dear Governor Carter:

One of our Company's consultants, Dr. Edward L. Gilbert of Burbank, California, has been in contact with Bob Havelly of your campaign staff concerning future national health plans. This is to recommend him as a thoroughly competent and reliable physician on whom we have depended rather substantially for the past several years.

As you may know, we have a substantial organization of professionally trained paramedical personnel - nurses, laboratory technicians, paramedics - who gather physical measurement and health history information for us in connection with life insurance and pre-employment examinations. Dr. Gilbert has been very helpful to us in employing, training and supervising these operations in a consultant way in the Pacific area.

Naturally, I have no knowledge of the specific plans that he has in connection with national health, but I can endorse him as a responsible physician.

Sincerely,



President

WLB:GF

Edward L. Gilbert, M.D.

2901 WEST OLIVE AVENUE
BURBANK, CALIFORNIA 91505

TELEPHONE 845-2631

July 13, 1976

**Senator Edmond Muskie
United States Senate
Washington, D.C.**

Dear Senator Muskie;

On January 27, and November 19, 1971 I wrote letters concerning my ideas about National Health Care. You showed an interest in my basic premise of primary care physicians in place of organizational medicine.

I have recently sent an outline of my proposed National Health Plan to the Carter Campaign and they too have showed an interest. I would appreciate you verifying my previous activity in this field to Governor Carter. I would like him to know I have been working on this plan for many years.

With your help I feel my ideas may be evaluated on their merits and not filed with all of the other material which Governor Carter is obviously receiving at this time.

Sincerely Yours,

Edward L. Gilbert, M.D.

**Edward L. Gilbert, M.D.
ELG/bjw**

**C.C.
Bob Havelly
Issues Dept.
Carter Campaign**

Edward L. Gilbert, M.D.

2901 WEST OLIVE AVENUE
BURBANK, CALIFORNIA 91505

TELEPHONE 845-2631

July 10, 1976

Bob Havelly
Issues Staff
Carter Campaign
P.O.Box 1976
Atlanta, Ga. 30301

Dear Mr. Havelly:

You may be right about sending my health plan directly to Governor Carter as you mentioned in our last phone conversation. Please go ahead and do so.

I would like the plan to be evaluated on its merits but please include the letter from W. Lee Burge of Equifax, a friend of Governor Carter.

I assume you have already sent a copy to Mary King.

Sincerely Yours,

Edward L. Gilbert, M.D.

Edward L. Gilbert, M.D.
ELG/bjw

EQUIFAX

Information for Business Decisions

Equifax Inc.

Post Office Box 4081
Atlanta, Georgia 30302

W. Lee Burge, President

May 20, 1976

Governor Jimmy Carter
Carter Campaign Headquarters
1789 Peachtree Rd., N. E.
Atlanta, Georgia

Dear Governor Carter:

One of our Company's consultants, Dr. Edward L. Gilbert of Burbank, California, has been in contact with Bob Havelly of your campaign staff concerning future national health plans. This is to recommend him as a thoroughly competent and reliable physician on whom we have depended rather substantially for the past several years.

As you may know, we have a substantial organization of professionally trained paramedical personnel - nurses, laboratory technicians, paramedics - who gather physical measurement and health history information for us in connection with life insurance and pre-employment examinations. Dr. Gilbert has been very helpful to us in employing, training and supervising these operations in a consultant way in the Pacific area.

Naturally, I have no knowledge of the specific plans that he has in connection with national health, but I can endorse him as a responsible physician.

Sincerely,

President

WLB:GF

(Hand delivered to Mr. Havelly)

Edward L. Gilbert, M.D.

2901 WEST OLIVE AVENUE
BURBANK, CALIFORNIA 91505

TELEPHONE 845-2631

July 28, 1976

Bob Havely
Issues Dept.
Carter Campaign
P.O. Box 1976
Atlanta, Ga. 30301

Dear Mr. Havely;

Please let me know the status of my health plan proposals. If Governor Carter is interested in my outline, I can personally present my entire project to policy makers on his staff. However, if my plan is not to be considered as a serious alternative I would like to be informed quickly. I would like the opportunity to try another prominent politician before November.

I have only presented my ideas to Senator Muskie four years ago and now to Governor Carter since I feel only a candidate for president needs a National Health Plan. My plans have not been published or presented through the medical society since I believe the ideas would then never seriously be considered by the law makers.

My goal is to improve medical care for all people in the United States before costs conscious politicians destroy the best system in the world. I expect no personal gain or fame, but only the opportunity to remain a family doctor.

Sincerely Yours,

Edward L. Gilbert, M.D.

Edward L. Gilbert, M.D.
ELG/bjw



Jimmy Carter

Presidential Campaign

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

March 26, 1976

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

Dear Ms. King:

Enclosed is our proposed draft of the health care paper. It has gone to the governor for his preliminary review; he has not yet seen it. We would like to have your comments, suggestions, and revisions. We are under some time pressure, so I'd appreciate your response in ten days or so if possible.

Thank you for your help, and I look forward to hearing from you.

Very truly yours,

Bob Havelly

Bob Havelly
Issues Staff

enc.

P. S. Please recognize that this is a confidential document. Thanks again. B. H.

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

LAW OFFICES
ALSTON, MILLER & GAINES

CITIZENS & SOUTHERN
NATIONAL BANK BUILDING
35 BROAD STREET
ATLANTA, GEORGIA 30303

404-588-0300
May 3, 1976

Search paper
5/11/76
WLL

Clark C. Havighurst, Esquire
Professor of Law
Duke University School of Law
Durham, North Carolina 27706

Dear Clark:

I have not forgotten our discussion when I was in Durham several weeks ago concerning the Carter Campaign and your interest in possibly suggesting positions in the health care field. I have discussed this matter with my partner Philip Alston, and he has determined that the best person on the Carter staff for you to contact in the health care area is Bob Havely. I am sending a copy of this letter to Mr. Havely, whose telephone number is (404) 897-7108 and whose mailing address is at the Carter Headquarters in Atlanta, Post Office Box 1976, Atlanta, Georgia 30301. I hope you will not hesitate to contact Mr. Havely.

As you can appreciate, we are delighted with the progress of the Carter Campaign and very optimistic about the future. I hope you will decide to share your thoughts with the Carter Organization.

Please give my best to Karen.

Warmest regards.

Sincerely,

L. Neil Williams, Jr.

lnw:jm

cc: Mr. Bob Havely

Blind P.S. to Mr. Havely: Philip Alston chatted with Stuart Eizenstat, and Stu suggested that you would be the best person for Clark Havighurst to contact. Clark has written fairly widely in the health care field, both as a result of a long-time interest in the subject area and, most recently, as a result of work done under a special grant from the National Center for Health Services Research, U.S. Department of Health, Education and Welfare. He is presently Director of a special program on legal issues in health care which is sponsored by the Duke University School of Law.

Thanks for the great job you are doing.

Neil
NEIL WILLIAMS



Jimmy Carter

Presidential Campaign

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

March 26, 1976

Mr. Tom Joe
720 A Street, S. E.
Washington, D. C.
20003

Dear Mr. Joe:

I enjoyed our conversation this morning, and I appreciate all the help you've given me.

Enclosed is our proposed draft of the health care paper. It has gone to the Governor for his preliminary review; he has not yet seen it. We would like to have your comments, suggestions, and revisions. We are under some time pressure, so I'd appreciate your response in ten days or so if possible.

Again, thank you for your help, and I look forward to hearing from you.

Very truly yours,

Bob Havely

Bob Havely
Issues Staff

enc.

P. S. Please recognize that this is a confidential document. Thanks again. B. H.

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

THE EQUITABLE LIFE ASSURANCE SOCIETY
OF THE UNITED STATES

1285 AVENUE OF THE AMERICAS, NEW YORK, N. Y. 10019

MORTON D. MILLER, F. S. A.
Vice Chairman of the Board

July 21, 1976

Mr. Stuart E. Eizenstat
P.O. Box 1976
Atlanta, Georgia 30301

Dear Mr. Eizenstat:

Just a quick note for myself as well as for Messrs. McClintock and Dorsch to acknowledge and thank you for your letter of July 8, 1976.

I'm sure you are more than familiar with the fulsome rhetoric surrounding the issue of National Health Insurance and do not wish to subject you to more of the same.

I am enclosing a copy of a statement I made recently on behalf of the Health Insurance Association before the Council on Wage and Price Stability because I think you will find it of interest. I firmly believe that the basic premise of the statement, namely, that we must all work together in a mutually supportive manner, is a sound one upon which to build a broad scale national program for health care or, for that matter, any other broad scale national program.

We will be considering more specific ways in which we can be helpful to you. We look forward to the possibility of discussing them with you before too long.

Sincerely yours,



M. D. Miller

cc: Messrs. J. B. McClintock
J. A. Dorsch

July 7, 1976

Health

Governor Jimmy Carter
Plains, Georgia

Dear Governor Carter:

I have forwarded to Stuart Eizenstat a copy of the accompanying outline of some ideas on a national health system that may be of interest to the Issues Committee in developing a policy on National Health Insurance.

Congratulations on securing the nomination; we will all be working to insure the same success in the November election.

Sincerely,



Corbett H. Turner, M.D.
Associate Professor of Psychiatry
and Preventive Medicine

CHT:pal

Enclosure

cc: Stuart Eizenstat ✓
Robert Lipshutz

Lawrence Miike, M. D., J. D.

May King
MAY 7 1976

ROUTE #3, BOX 221-F
BERKELEY SPRINGS, WEST VIRGINIA 25411

TEL. MESSAGES THRU:
SWEET LOCUST FARM
(304) 258-3729

April 22, 1976

To: Phil Lee

Subject: Carter's Medical Malpractice Position.

Considering the nature and brevity of this type of policy statement, I think it's pretty good. To avoid being picky, let me comment on just a few things.

It could state more forthrightly that the issue is how to compensate people injured in the process of medical treatment. What we do to control the injury rate, to modify or replace the present tort process of seeking compensation, and to stabilize the insurance financing system should all ultimately be measured against how well they do this.

On his three basic elements, in the first, replacement of the present system, it's unclear to me what the exact proposal is. He seems to be advocating that the courts be reserved for gross negligence cases, arbitration to be used otherwise. In addition, awards (my emphasis) would be based on unanticipated results, and not on negligence. I presume this means that an administrative determination would be made on whether an injury has occurred and whether that result was unanticipated, the question of negligence being moot unless gross negligence arose. I assume that in this system, indications of negligence would be reported to the medical board for possible discipline, and a catalogue of compensable events developed. (The way it's written, another interpretation could be that only allegedly negligent cases would be administratively reviewed, with awards given only if unanticipated results occurred. If predictable bad results occurred, then you have a preliminary determination of gross negligence, and the review board would be screening cases for possible judicial action the way most arbitration boards now work in ordinary negligence cases.)

At any rate, what I believe is being proposed is a combination of two principles: a) compensation for injury within specified limits, and b) some retention of the punitive (deterrent) aspects of personal liability suits when more than ordinary negligence may have occurred.

I have doubts whether these two approaches can remain separated, and think that "gross negligence" would in time be what we think of as ordinary negligence. Rather than the schema proposed, one slight alteration of it could be to retain the gross negligence concept, but

only in terms of economic or practice limitation sanctions against the defendant and not as an incentive to plaintiffs to get more. To illustrate, awards would be determined by the severity of injury regardless of cause. Therefore, to plaintiffs, the size of the award would not be related to the degree of fault of the defendant. In the instances where ordinary negligence is replaced by the proposed system, whether or not awards are made would depend on the unanticipated nature of the injury. In gross negligence cases, the award to the plaintiff would be the same for comparable injuries, but the sanction against the defendant would be different; i.e., curtailment of practice and/or economic penalty(not covered by insurance). The latter could be paid into the insurance pool.

Another alternative is to drop the negligence approach completely, but that's impractical (and anyway, I'm only commenting on the proposal and not trying to alter it).

Elements two and three are straightforward, though as to the self-insurance pool, it should be clear that without a restructuring of the tort system approach, it's not a long-term solution. Element two, revision of physician licensure laws, could stand alone, since it is equally or perhaps more applicable to the issue of quality than to malpractice.

I would generally go along with this policy statement, although it needs sharpening - perhaps not for a brief statement like this, but certainly for what can be spelled out beyond the outline here.

Larry Minke

Neil- pls. file, copy on [unclear] [unclear]

GASTONIA PEDIATRIC ASSOCIATES, P.A.
~~321 NEW HOPE ROAD~~
GASTONIA, NORTH CAROLINA 28052

GERARD MARDER, M.D.

ROBERT E. CHAMBERS, M.D.

FREDERICK C. NORCROSS, M.D.

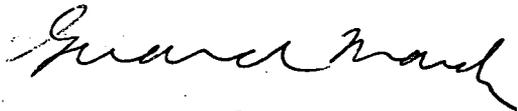
August 6, 1976

Advisor-in-Chief
Health Affairs
Carter for President Campaign
Atlanta, Georgia

Dear Sir or Madam;

William Anlyan, M. D. Dean of Duke Medical Center, is one Southerner that the Carter Administration, in my opinion, cannot afford to neglect. His expertise, diligence, humility, and ability to take an overall view of Health Affairs has made me a devotee of his for years. Carter would profit to have the benefit of this knowledgeable man as a resource in Health Affairs problems.

Yours sincerely,



Gerard Marder, M.D.
Gastonia Pediatric Assoc., P.A.
1839 East Garrison Blvd.
Gastonia, N.C. 28052
(704) 864-2685

August 10, 1976

Dr. Gerard Marder, M.D.
Gastonia Pediatric Assoc. P.A.
1839 East Garrison Blvd.
Gastonia, North Carolina 28052

Dear Dr. Marder:

Thank you for your letter of August 6. I have written to Dr. Anlyan to ask for the benefit of his assistance during our fall campaign. I appreciate your bringing his name to my attention.

Any other ideas, thoughts or suggestions you may have would be very helpful. Thanks again for your advice and for your support.

Sincerely,

Robert S. Havely
National Issues and Policies

RSH:dan

August 10, 1976

Dr. William Anlyan
Dean
Duke University Medical Center
Duke Station
Durham, North Carolina 27706

Dear Dr. Anlyan:

Dr. Gerard Marder has written me to suggest that your expertise would be of great benefit to the Carter campaign in the area of health-related issues.

We have been fortunate to have the help of knowledgeable persons in many fields throughout the campaign, and I would welcome any ideas or suggestions you may have.

I look forward to hearing from you.

Sincerely,

Robert S. Havely
National Issues and Policies

RSH; dan

September 29, 1976

Mr. John H. O'Connor
392 Central Park West, 14E
New York, New York 10025

Dear Mr. O'Connor:

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 am handling health care issues on the staff level during the campaign.

I appreciate your ideas and interest in the Carter campaign; Governor Carter shares your concern about the rising costs of health care. I am enclosing a copy of a speech on national health policy in which he addresses costs and other important issues.

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

Sincerely, *Robert S. Hovely*

Robert S. Hovely
Health Issues Coordinator
National Issues and Policy

392 Central Park West 14E
New York, n.y. 10025
August 9, 1976

Jimmy Carter
Plains, Ga.

Sir:

In the upcoming campaign, one of the issues will be National Health Insurance. President Ford has his proposal for "catastrophic loss" insurance, Senator Kennedy, his plan, and so forth.

The problem is cost, followed closely by administration. No one questions the need, for all of us are mortal, and therefore prone to illness and accident.

This presents, I believe, the opportunity to consider a refreshing position, something in a positive vein. And that is to question why the need for insurance arises, and then to question whether present health delivery systems are suitable for the present day (i.e. longer life span, smaller percentage of the population comprising the work force, etc.)

The big hassle, as I see it, with health insurance is the cost of the private doctor (in the neighborhood) system we now have. It's costly and inefficient. And Doctors who feel the Medicare reimbursements are too meager to begin with, are frustrated by the paperwork involved in collecting them. What's more basic is that the present system is ad hoc in nature, taking care of people only after illness has struck. Rather than monitoring people over the years to detect in advance possible symptoms of serious disease.

A position that would answer advocates of National Health Insurance while simultaneously quelling the justifiable fears of those who cite the horrendous cost implications, might be to advocate a rethinking of our health delivery system, with consideration of HMO's and outpatient clinics as an alternative. This would shift the emphasis from decentralized health delivery to centralized systems, and from post illness treatment to preventive medicine. The

HMO concept, in particular, with it's built-in incentive to keep people healthy through regular check-ups and nutrition counseling, makes a lot of sense. It's compassionate in the sense of recognizing mankind's mortality, yet fiscally responsible since it is fixed in cost and can be budgeted for.

The draw back to all such "clinic" approaches is the impersonal treatment you sometimes get. And that's a serious problem, especially to the poor and in this city, non-english speaking population.

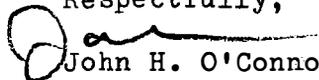
Yet something has to be done. The population is growing but the workforce is diminishing. It's time to think in terms of new solutions to frustrating problems.

In short, your position could be as follows:

"While my opponent speaks in terms of catastrophic loss, I would urge the Congress to consider new systems of health delivery that would emphasize preventive medicine, rather than waiting until illness strikes and then reimbursing the costs of getting well. One idea is the Health Maintenance Organization which is paid a flat fee for every patient registered, regardless of the number of visits. This effectively puts the emphasis on prevention since it's in the best interest of the HMO to minimize patient visits, thereby making a profit. It also means that health care in this country could be budgeted realistically; the cost of the HMO plan being deducted from worker's paychecks in the same manner as Social Security. Each pays according to his ability. And it would put administration of the program in the private sector, close to the people it serves. It's time we think in this country of new ways of solving our problems and taking care of our people's needs. HMO's may not be the answer, but it's an idea we ought to be thinking about."

Good Luck in November!

Respectfully,


John H. O'Connor

St. Vincent Infirmary

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September 13, 1976

The Honorable Jimmy Carter
P.O. Box 1976
Atlanta, Georgia 30301

Dear Governor Carter:

I am attaching a copy of a letter which I am mailing to Senator Dale Bumpers to ask his aid in dealing with the bureaucracy in Washington.

I know that you have assembled a staff of advisors to aid you in formulating plans to deal with the delivery of health care to all Americans. I have reason to suspect that you are not being well advised. I would hope you would seek input from those of us who are at the operational level. Too many plans have been formulated by personnel who really know very little about that which they are trying to control.

Your attention to this matter is greatly appreciated. If you would like further information or my assistance, I will be happy to devote some time to helping you.

Sincerely,

A handwritten signature in cursive script that reads "A. Jack Reynolds".

A. Jack Reynolds
Administrator

AJR/ms

HOW STUPID CAN WE GET?

Will we sit idly by and accept without question unjustified and unnecessary rules that hamper rather than help the operation of our health care institutions? Dr. David Mathews is fighting 'stupid' rules and regulations daily and he needs your help. Will you take just a few minutes to write down a list of rules and regulations that you feel are hard or downright impossible to function efficiently under and send these to Dr. Mathews. As he said in his speech in Huntsville, "There are things we can do that will not save the world but will certainly make things a lot better," --- that is if we are not operating with too great a handicap!

The Birmingham News

Sat., July 17, 1976

Mathews tells bar he's fighting the 'deadly sin' of stupid rules

BY PATHOUTZ
News correspondent

HUNTSVILLE — U. S. Health, Education and Welfare Secretary David Mathews says he is sending some of the federal officials who write "stupid regulations" to work in some of the areas they are regulating.

And, he told the Alabama Bar Association Friday, he is bringing in outside observers and getting public input before new regulations are placed into effect.

MATHEWS, on leave as president of the University of Alabama, said one of Washington's deadly sins is regulations which don't achieve desired results and often seem stupid.

He said the government also often is isolated from the people, is remote and inaccessible, is repressive, is incompetent and can be "ripped off."

"We underestimate the good will and good sense of local administrations which often can do as well or better

than federal regulation." Mathews told the lawyers.

"There are things we can do that will not save the world but will certainly make things a lot better," he said.

The lawyers gave Mathews a standing ovation when John Caddell, president pro tem of the University of Alabama board of trustees, said, "We hope and expect you to return to Alabama when your work in Washington is done."

September 29, 1976

A. Jack Reynolds, Administrator
St. Vincent Informary
Markham University
Little Rock, Arkansas 72201

Dear Mr. Reynolds:

Thank you for your letter of September 13. 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 information you sent along. I am enclosing for your review a speech on national health policy, which outlines Governor Carter's philosophy on cost controls, access to medical care, and National Health Insurance. I would appreciate having your thoughts on the Governor's approach to these problems.

Any further ideas or information you might wish to send would be most helpful. Thank you again for your interest and support.

Sincerely,

Robert S. Hovely
Robert S. Hovely
Health Issues Coordinator
National Issues and Policy

The Pain and Health Rehabilitation Center,[®] S.C.

C. NORMAN SHEALY, M.D.

615 South Tenth Street
La Crosse, Wisconsin 54601
(608) 782-1560

Issues
Dept

August 11, 1976

Governor Jimmy Carter
Plains, Georgia 31780

Dear Jimmy:

One of my neurosurgical colleagues from Buffalo has just prompted me to write you about this. It is a universal problem in this country with insurance companies lead by Blue Cross-Blue Shield. If he has a patient who needs a special type of x-ray called a CAT scan, the scan costs about \$250.00. Blue Cross-Blue Shield will not pay the fee if it is done on an out-patient basis, but they will pay the fee if the patient is admitted to hospital. This means that the patient is put into the hospital for 2 days usually at about \$100.00 a day for the hospitalization plus the necessity for doing also a CBC, SMA 12 and chest x-ray, which are likely to add up to another \$75.00. Thus, the minimum cost has been more than doubled by this attitude on the part of insurance companies. I consider this one of the greatest albatrosses and bits of hypocrisy in the entire medical world today.

If your proposed national health insurance does not find a way around this, it almost certainly will bankrupt the country.

Sincerely yours, M.D.



C. Norman Shealy, M.D.

CNS/cfh

P.S. This is of course, not just the CAT scan, it is almost anything we want to do. In addition, insurance companies are very erratic about what they will cover, even from state to state. One company will cover biofeedback training and another will not, etc.

n

September 29, 1976

C., Norman Shealy, M.D.
The Pain and Health Rehabilitation Center
615 South Tenth Street
La Crosse, Wisconsin 54601

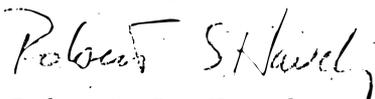
Dear Dr. Shealy:

Thank you for your letter of August 11. I apologize for taking so long to reply. Governor Carter has referred it to me as I am handling health care issues on the staff level during the campaign.

Governor Carter shares your concern about the soaring cost of health care. I am enclosing a copy of his speech on national health policy which outlines the Governor's philosophy on cost controls. I would appreciate having your thoughts on his approach to this problem.

Thank you again for your interest and support.

Sincerely,



Robert S. Hovely
Health Issues Coordinator
National Issues and Policies

Porto Carras

Maria Rolfe - 860 U.N. Plaza New York N.Y. 10017

Athens, September 10th, 1976

Dear Mr. Havelly,

Forgive belated reply to your letter of August the 16th, 1976. Unfortunately the shingles forced me on board a ship for a rest and I am now in Athens where your letter reached me.

I believe that detailed material with regard to cancer treatment methodologies, namely the Revici Cancer Control "Institute of Biology" and "Laetrile" have already been sent to Governor Carter's office.

Naturally there are hundreds of individuals and institutions working on cancer research. Those which I believe to be the most effective have not yet been recognized by the Medical profession. Though many individuals are in fact taking the risk of using these yet unproven methods. On the basis that no cure for cancer exists I believe that a thorough probe of the national cancer program and a "freedom of choice" bill are essential for the welfare of the Nation.

On my return to New York on September the 30th, I will send you more material in this connection. In the meantime I have written to ask those who have had considerable experience in this field, to write to you.

I am eager for Governor Carter's election as President and will do whatever possible to help.

Many thanks for your interest and prompt reply.

Sincerely,



Maria Rolfe

Your ref.:RSH:dan

Fringe

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- Group Health Planning

August 20, 1976

And — For Business

- Employee Public Relations
- Executive Fringe Benefits
- Business Continuation Planning

Mr. Bob Havely
Carter Campaign Headquarters
Post Office Box 1976
Atlanta, GA 30301

RE: National Health Plan

Dear Mr. Havely:

We were pleased to learn that you have arrived on the scene and that you will be assisting Mr. Carter in the area of the national health insurance issue.

Enclosed you will find a copy of a letter written to Neil Sader on August 3. You will also find some additional material about me.

As a lifelong Democrat and Co-chairman of the Life Underwriters Political Action Committee for the state of Florida, I am additionally involved in who our 150,000 members will endorse and work for in the upcoming campaign.

I am sure you have seen the Institute of Life and Health Insurance ads on TV which say, "We are the 900,000 people of the health insurance industry, what we do makes a difference."

Our basic concern from the grassroots level is the possibility of literally being legislated out of existence should a Kennedy-Corman type national health plan be instituted under the direction of H.E.W.

"We represent you"

I supported Jimmy Carter here in the state of Florida in the Democratic primary because I believed his antiestablishment, free enterprise campaign indicated to me that he would in no way impair the private sector in providing a solution to the national health plan problem. I also took his campaign to mean that there would be no advantage to the American public in creating another huge layer of Federal bureaucracy and legislate 900,000 people out of a job that they are uniquely qualified to provide under Federal regulation as outlined in our own national health plan bill, the Burleson-McIntyre Bill.

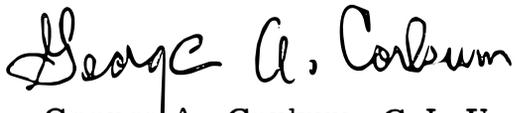
There is also a very strong constitutional question as to whether the Federal government can usurp the state regulated insurance industry under Article 10 of the Constitution in providing a plan totally under Federal control and administration.

We in the insurance industry as a group are as vitally concerned that every American citizen receive quality medical care at a cost we can all afford and sincerely believe that if we are to look at all of the pending legislation, a compromise can be worked out where everyone will be happy.

That is why it is imperative that we learn from you what would be an appropriate time for us to meet with you in Atlanta. Please advise and thank you.

Most cordially,

FRINGE BENEFIT CONSULTANTS, INC.



George A. Corkum, C.L.U.
Executive Director

GAC/lh

August 3, 1976

PERSONAL

Mr. Neil Sader
Carter Campaign Headquarters
P. O. Box 1976
Atlanta, Georgia 30301

Dear Mr. Sader:

Congratulations on a winning primary result. This is the letter I promised would follow after our phone conversation last week.

We are very much interested in meeting with your new staff member who will be assigned to work on the National Health Plan issue. The "we" are representatives of Health Insurance Association of America and the National Association of Life Underwriters. H.I.A.A. represents the 314 companies writing most of America's personal and group health insurance. N.A.L.U. represents over 140,000 professional life and health insurance agents who currently service the present private sector health insurance industry in literally every precinct throughout the U.S.

We are in favor of a federally regulated, private sector administered (state by state) approach to a National Health Insurance plan, and we sincerely believe we can accomplish this goal faster and at less cost to the taxpayer than another federal layer of bureaucracy.

We need to show how this can be accomplished in a fashion satisfactory to Mr. Carter's position and to begin discussions which will produce the result we have so long endorsed -- quality medical attention, for all Americans, at a price they can afford.

-- more

Mr. Neil Sader
August 3, 1976
page 2

Would you be so kind as to direct our inquiry to the proper person,
and let us know what would be a convenient time for him to meet with
us in Atlanta.

Please advise, and thank you.

Most cordially,

George A. Corkum, C.L.U.
National Association of Life
Underwriters
Public Relations Chairman

jad

cc: Bill Bartlett, N.A.L.U.
Marv Kobel, N.A.L.U.
Stuart Eizenstat
Robert Froehlke, H.I.A.A.
Bruce Hendrickson, N.A.L.U.
Stan Stone, F.A.L.U.

We Have A Candidate – By George!

The NALU Nominating Committee has placed the name of Florida's George A. Corkum, CLU, on the official slate of recommended candidates for the office of NALU Trustee. The election will take place at the NALU Convention, Hotel Fontainebleau, Miami Beach, September 19-23.

This, quite obviously, means that FALU is now deeply involved in campaign plans for his candidacy. We certainly want George to be first on the ballot when the votes are counted. Since the NALU Trustee



election is in actuality a popularity contest, we feel that we will be presenting one of the most "popular" candidates. Those who know and have met George, are certainly versed in his qualifications and background. Apart from his outstanding years of service to FALU, which includes Regional Vice President, Senior Vice President and FALU President (1973-74), George has also served with distinction the past two years as chairman of NALU's Public Relations Committee. Uppermost among his contributions to NALU was his

suggestion and eventual implementation of NALU's current, ambitious CBS radio network series of advertising spots featuring the life underwriter member. If you heard the All-Star baseball game on CBS radio, July 13, you must have glowed with pride when the musical jingle was played.

Perhaps best known of all George's accomplishments to our industry is the outspoken hard-nosed approach he has taken towards any federally-funded, all-encompassing, badly-conceived national health insurance proposal. A vehement critic of "government pay all" forces lurking behind these proposals, George has been heard often on radio and TV, debating the issues with key people representing the other side.

The FALU and NALU national health position was presented by George to the entire Florida Congressional delegation at a special luncheon in Washington, D.C. Following his remarks, letters were sent by Florida Congressmen thanking George and FALU for providing them with such complete data on the Burluson-McIntyre Bill, as well as our logical, common-sense approach to a national health plan.

We certainly encourage all FALU'ers to make their plans now to be in attendance at the gala national convention to be held in our state this September. You will be host to thousands of NALU members and we hope you will not miss out on this golden opportunity to attend one of these outstanding NALU conventions.

This time there is no excessive plane travel, and other bothersome details usually accompanying attendance at a national convention. All we ask is that you mail in your advance discount registration form as quickly as possible. If you plan on staying at one of the five cooperating convention hotels housing the convention, either mail away your LAN housing form or write to FALU Headquarters in Tampa for another one.

Another distinct supportive gesture you can provide for George Corkum is to write to any of your friends around the country who plan on attending the NALU convention and invite them to visit the Florida Hospitality Suite to meet our candidate.

There is no doubt that FALU this year has an eminently qualified Trustee candidate – by George!

Award Winner

"Babe," the Babe Didrikson of Tampa, has re-nomination as dramatic special television season, overwhelming acceptance of million viewers claim of the CBS-TV will remember. The two again be sponsored Communications Life and Health.

MCP recently effectiveness of commercials and people in the our business. A well over 1,000 state and local survey uncovered

1. 88% have shows and
2. 90% rate to excellen
3. The high due to the cept stres cials as r contact st lie.
4. 93% are ing these

Your FALU record as statin MCP shows an are excellent, in a more than reflecting the si interest accord majority of ov



LADIES NIGHT featured "sur speaker, Mrs wife of form John Mincher was a hit at t evening mee the big awar

Inter.

1-800-257-2231

Mr. George Corbun
Public Relations Chairman
National Association of Life Underwriters
Fountainbleu Hotel
Miami Beach, Florida

Dear Mr. Corbun:

I enjoyed our conversation of last week. I was pleased to learn of the upcoming meeting of the National Association of Life Underwriters, and I hope your meeting is productive and successful.

Governor Carter supports the establishment of a national program of health care for our people whose goal is regular access to high quality care for all our citizens at a price they - and our nation - can afford.

The high cost of care, the waste and abuse in ^{our} existing programs, the uneven distribution of physicians, the lack of emphasis on primary and preventive care ~~with our citizens and represent~~ shortfalls in ~~the~~ the health of Americans that shortchange us all.

In developing a plan for national health insurance, the Governor has consistently refused to accept ~~the~~ the premise that there is no constructive or affirmative role for the private insurance carriers to play. The ~~same~~ private ~~insurance~~ insurance industry is an important part of our economy. It has developed a wealth of experience and expertise. In addition to his philosophical commitment to the importance of private enterprise, Governor Carter is committed to insuring that ~~the~~ ^{our} health program is

carried out as efficiently and effectively as possible. [It is within this perspective that Governor Carter is ~~pursuing~~ ^{pursuing} ~~the~~ ^{his} objective of assuring a productive role for the private ^{insurance} industry in the program. With his emphasis on a carefully planned and responsible phased-in approach to national health insurance, this objective is increasingly important.]

This ~~the~~ ^{the} campaign needs to continue to benefit from ^{your valuable} ~~the~~ advice and suggestions, and from the ideas and insights of the other members of the National Association of Life Underwriters. Governor Carter has instructed that all responsible viewpoints must be sought out and included in this complex process. I look forward to leaving from you soon, and I hope this ^{the Core-Model Campaign} ~~we~~ can continue to work together for an effective and responsible solution to our health with the private health insurance industry.

Yours,

Smiley,

Bob Kline,
Health Issues Com.

Nat. Issue & Policy

Carter / Mondale Campaign
PO Box 1616 ATL GA 30301

IT IS WITHIN THIS PERSPECTIVE, THAT GOVERNOR CARTER IS ATTEMPTING TO PURSUE THE OBJECTIVE OF INCLUDING A PRODUCTIVE ROLE FOR THE PRIVATE INSURANCE INDUSTRY IN THE PROGRAM.

AND WITHIN THE FRAMEWORK OF A CAREFULLY PLANNED AND RESPONSIBLE PHASED-IN APPROACH TO NATIONAL HEALTH INSURANCE,

Bob H

M*
NEXPRESZ ATL
4PM EDT OCT 2
AABI77(1500)(2-008146C276)PD 10/02/76 1453
ICS IPMSFSG SFO
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ATLANTA GA 30301

SIR:

QUESTIONS FOR JOURNAL, CALIFORNIA DENTAL ASSN ENCLOSED.
IMPERATIVE THAT ANSWERS BE RECEIVED BY OCT 8 TO MEET
DEADLINE. FORD HAS ALREADY ANSWERED. HAVE DISCUSSED WITH ROB FURTH
RESPOND TO CDA 6151 WEST CENTURY BLVD LOS ANGELES CA
AS SOON AS POSSIBLE

1. DO YOU FAVOR A NATIONAL HEALTH INSURANCE PROGRAM?
2. HOW COMPREHENSIVE SHOULD SUCH A PROGRAM BE?

- A. WHAT AGE GROUPS SHOULD BE COVERED?
- B. WHAT INCOME GROUPS SHOULD BE COVERED?
- C. WHAT TYPES OF HEALTH CARE SHOULD BE PROVIDED?

3. HOW SHOULD SUCH A HEALTH INSURANCE PROGRAM BE IMPLEMENTED,
(I.E., IN TOTO OR PHASED IN) AND IF PHASED IN, ON WHAT SCHEDULE?
4. WHAT DO YOU ESTIMATE THE ANNUAL COST OF SUCH AN
INSURANCE PROGRAM TO BE, AND HOW WOULD IT BE FUNDED?
5. WOULD YOU RECOMMEND THE PROGRAM TO BE ADMINISTERED BY
GOVERNMENT AGENCY(S) OR PRIVATE INDUSTRY?

MANY RESPONSIBLE AGENCIES WHICH HAVE STUDIED THE PHENOMENAL RISE
IN INSURANCE PREMIUMS FOR PROFESSIONAL LIABILITY (MALPRACTICE)
COVERAGE OF PHYSICIANS AND DENTISTS FEEL THAT THE PROBLEM IS DUE IN
GREAT PART TO TWO BASIC FLAWS IN OUR PRESENT SYSTEM:

- 1) TORT LAWS WHICH INVITE LEGAL ACTION WHERE THE ACTUAL

ISSUE IS ONE OF UNMET EXPECTATIONS RATHER THAN MALPRACTICE PER SE;
AND 2) THE PRESENT CONTINGENCY FEE ARRANGEMENT FOR ATTORNEYS THAT CAN

ENCOURAGE WHOLESALE FILINGS OF ACTIONS, MANY OF DUBIOUS MERIT.

6. DO YOU AGREE OR DISAGREE WITH THESE OBSERVATIONS?
7. WHAT DO YOU RECOMMEND?
8. DO YOU FEEL PHYSICIANS AND DENTISTS SHOULD BE ALLOWED TO
ADVERTISE THEIR FEES FOR INDIVIDUAL SERVICES?
9. IF SO, WOULD YOU PROPOSE ANY FEDERAL LEGIALTION TO FACILITATE SUCH
ADVERTISING?
10. DO YOU BELIEVE IT IS WITHIN THE FTC'S JURISDICTION TO
INVESTIGATE THE LAWFULNESS AND EFFECTS OF CURRENT STATE
RESTRICTIONS ON THE SALE OF DENTURES DIRECTLY TO THE
PUBLIC, PARTICULARLY CONSIDERING THAT MANY OF THESE

Telex/TWX western union

RESTRICTIONS HAVE BEEN UPHELD BY STATE SUPREME COURTS?

IT APPEARS THE FTC IS ALSO ACTIVELY PURSUING MANY ANTITRUST CASES THAT PARTICULARLY INVOLVE PROFESSIONALS AND INTEND TO THWART ANTICOMPETITIVE PRICE-FIXING OR RESTRAINT OF TRADE PRACTICES. ON THE OTHER HAND, THE DEPARTMENT OF HEALTH, EDUCATION AND WELFARE HAS BEEN PROMOTING PROGRAMS THAT REDUCE COSTS, BUT ARE, IN ESSENCE, ANTICOMPETITIVE, SUCH AS FIXED-FEE PROGRAMS UNDER MEDICARE AND MEDI-CAL.

IT HAS BEEN PREDICTED THAT THESE TWO POWERFUL AGENCIES ARE ON A COLLISION COURSE.

11. DO YOU BELIEVE THIS IS TURE?

12. WHAT DO YOU SEE AS THE FEDERAL GOVERNMENT'S ROLE IN THE RELATIONSHIP BETWEEN THE CONSUMER AND THE PROFESSIONAL?

AT PRESENTI, THE FEDERAL GOVERNMENT MATCHES ALL FUNDS PROVIDED

BY EACH STATE FOR THE DENTAL CARE OF WELFARE RECIPIENTS. HOWEVER, NOT ALL STATES MAKES EXPENDITURES FOR DENTAL BENEFITS, AND THEREFORE, THE FEDERAL FUNDS CAN NOT BE MATCHED AND NO WELFARE DENTAL PROGRAM IS MADE AVAILABLE.

13. DO YOU BELIEVE THAT DENTAL CARE IS AN ESSENTIAL PART OF HEALTH CARE, SUCH THAT NO GOVERNMENT PROGRAM SHOULD BE WITHOUT IT?

14. FEES FOR HEALTH CARE PROVIDERS SERVICING WELFARE RECIPIENTS ARE WELL BELOW THE MEDIAN FEES CHARGED UNDER VIRTUALLY ALL PRIVATE PROGRAMS.

DO YOU FEEL THIS COMPENSATION IS FAIR FOR THESSE PPRRROONFFFFFES■
XXX

DO YOU FEEL THIS COMPENSATION IS FAIR FOR THESE PROFESSIONALS?

15. IF SO, SHOULD ALL PROVIDERS OF SERVICES TO THE STATE BE REIMBURSED ON A SIMILARLY REDUCED SCALE?

16. DO YOU FEEL THERE IS A SHORITAGE OF HEALTH MANPOWER, AS OPPOSED TO MALDISTRIBUTION?

17. IF SO, HOW WOULD YOU SUGGEST SUCH PROBLEMS BE SOLVED?

CALIFORNIA DENTAL ASSN
6151 WEST CENTURY BLVD
LOS ANGELES CA 90049
NNNN

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western union

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2-050264E261002 09/17/76 ICS IPMTZZ CSP ATLR
1 4048975091 MGM TDMT ATLANTA GA 09-17 0322P EST

▶ ROBERT S HAVELY
1162 IVY CT
DECATUR GA 30033

THIS MAILGRAM IS A CONFIRMATION COPY OF THE FOLLOWING MESSAGE:

4048975091 MGM TDMT ATLANTA GA 335 09-17 0322P EST
ZIP
GEORGE CORKUM
PUBLIC RELATIONS CHAIRMAN
NATIONAL ASSN OF LIFE UNDERWRITERS
FOUNTAIN BLEU HOTEL
MIAMI BEACH FL 33139
DEAR MR CORKUM:

I ENJOYED OUR CONVERSATION OF LAST WEEK. I WAS PLEASED TO LEARN OF THE UP COMING MEETING OF THE NATIONAL ASSOCIATION OF LIFE UNDERWRITERS, AND I HOPE YOUR MEETING IS PRODUCTIVE AND SUCCESSFUL.

GOVERNOR CARTER SUPPORTS THE ESTABLISHMENT OF A NATIONAL PROGRAM OF HEALTH CARE FOR OUR PEOPLE WHOSE GOAL IS REGULAR ACCESS TO HIGH QUALITY CARE FOR ALL OUR CITIZENS AT A PRICE THEY- AND OUR NATION- CAN AFFORD.

THE HIGH COST OF CARE, THE WASTE AND ABUSE IN OUR EXISTING PROGRAMS, THE UNEVEN DISTRIBUTION OF PHYSICIANS, AND THE LACK OF EMPHASIS ON PRIMARY AND PREVENTIVE CARE REPRESENT SHORT FALLS IN THE HEALTH OF AMERICANS THAT SHORT CHANGE US ALL.

IN DEVELOPING A PLAN FOR NATIONAL HEALTH INSURANCE, THE GOVERNOR HAS CONSISTENTLY REFUSED TO ACCEPT THE PREMISE THAT THERE IS NO CONSTRUCTIVE OR AFFIRMATIVE ROLE FOR THE PRIVATE INSURANCE CARRIERS TO PLAY. THE PRIVATE INSURANCE INDUSTRY IS AN IMPORTANT PART OF OUR ECONOMY. IT HAS DEVELOPED A WEALTH OF EXPERIENCE AND EXPERTISE. IN ADDITION TO HIS PHILOSOPHICAL COMMITMENT TO THE IMPORTANCE OF PRIVATE ENTERPRISE, GOVERNOR CARTER IS COMMITTED TO INSURING THAT HIS HEALTH PROGRAM IS CARRIED OUT AS EFFICIENTLY AND EFFECTIVELY AS POSSIBLE. IT IS WITHIN THIS PERSPECTIVE, AND WITHIN THE FRAMEWORK OF A CAREFULLY PLANNED AND RESPONSIBLE PHASED-IN APPROACH TO NATIONAL HEALTH INSURANCE, THAT GOVERNOR CARTER IS ATTEMPTING TO PURSUE THE OBJECTIVE OF INCLUDING A PRODUCTIVE ROLE FOR THE PRIVATE INSURANCE INDUSTRY IN THE PROGRAM.

THIS CAMPAIGN NEEDS TO CONTINUE TO BENEFIT FROM YOUR VALUABLE ADVICE AND SUGGESTIONS, AND FROM THE IDEAS AND INSIGHTS OF THE OTHER MEMBERS OF THE NATIONAL ASSOCIATION OF LIFE UNDERWRITERS. GOVERNOR CARTER HAS

INSTRUCTED THAT ALL RESPONSIBLE VIEWPOINTS MUST BE SOUGHT OUT AND INVOLVED IN THIS COMPLEX PROCESS. I LOOK FORWARD TO HEARING FROM YOU SOON, AND I HOPE THAT THE CARTER MONDALE CAMPAIGN CAN CONTINUE TO WORK TOGETHER WITH THE PRIVATE HEALTH INSURANCE INDUSTRY FOR AN EFFECTIVE AND RESPONSIBLE SOLUTION TO OUR HEALTH CONCERNS. SINCERELY

▶ ROBERT S HAVELY
HEALTH ISSUES COORDINATOR
NATIONAL ISSUES AND POLICY
CARTER MONDALE CAMPAIGN
PO BOX 1976
ATLANTA GA 30301

15:22 EST

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1995 E. Oakland Park Blvd. • Fort Lauderdale, Florida 33306
Telephone 563-2631

September 29, 1976

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- Business Continuation Planning

Mr. Robert S. Havely
Health Issues Coordinator
National Issues and Policy
Carter-Mondale Campaign
Post Office Box 1976
Atlanta, Georgia 30301

Dear Mr. Havely:

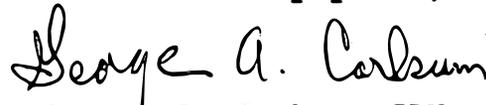
Thank you very much for your Mailgram regarding Governor Carter's position on the national health insurance issue. The material was turned over to the leadership of NALU, and duly noted.

My tenure of office as Public Relations Chairman for NALU ended at the Miami Convention, and I am turning this file and material over to our leadership in Washington for their follow-up. I am also directing a copy of this letter to Mr. Robert Froehlke who is the new president of the Health Insurance Association of America.

He and I discussed the importance of a meeting with your people, and we are still very much interested in arranging for such a meeting either in Atlanta, Georgia, or in Washington if Dr. Peter Bourne and Mary King cannot make the trip to Atlanta. Mr. Froehlke and my successor will be in contact with you regarding the possibility of such a meeting.

In closing, may I offer my sincere thanks to you for all of the time and attention you personally have involved yourself with on this entire question.

Most cordially yours,



George A. Corkum, CLU
Executive Director

jad

cc: Bill Bartlett, NALU
Marv Kobel, NALU
Robert Froehlke, HIAA
Bob Forker, NALU President

"We represent you"

From the Desk of

NORM ZIMLICH



Hi Tom,

Here's the fancy final
copies of the HEW Planning
Study, which was the
"precursor" to the FRC
supermarket report.

Also enclosed are a bunch
of brochures on the same,
which are probably more useful
because they're succinct.

Say the word and I'll
grab my slides + my smile
and hop a plane (bus?)
for Athens.

Norm



STARBUST

MOTOR LODGE

Phone 522-2910

Area Code 208

700 Lindsay Blvd.

Idaho Falls, Idaho 83401

7/20
Dept

Governor Jimmy Carter
Plains, Georgia

Issue
OSHA

Dear Gov. Carter:

As you approach the Presidency, I'm sure that many things are on your mind. I'm writing about only one and that is the OSHA staffing.

accepted safety & health demands

Too many appointments were made in the early days of its life - and many people got into higher level positions because of political and/or civil service sensitivity considerations. I saw it as quite a disillusionment as one of the early compliance officers who thought we had a

chance to make a genuine contribution to safety in this country - and I returned to my former employer.

at the recent conference of the American Society of Safety Engineers, Dr. M. Corn spoke of the new professionalism he is injecting into OSHA. It is my hope that you will continue this plan and even accelerate it. and make attempts to weed out those who are not capable of handling the job as a true professional, thus preventing injuries and not writing a series of tickets.

Thank you for your consideration.

Very truly yours,

William J. Lashy, PE, CSP

2212 Mayfield Ave
Joliet, Ill. 60435

I

September 25, 1976

Mr. William J. Larson
2212 Mayfield Avenue
Joliet, Illinois 60435

Dear Mr. Larson:

Thank you for your letter of July 26. 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 comments about the problems in the Occupational Safety and Health Administration. Governor Carter is committed to restoring professionalism to a streamlined and effective OSHA. I am enclosing for your review Governor Carter's position on this issue.

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

Sincerely,

Robert S. Havely
Health Issues Coordinator
National Issues and Policy

RSH:j

Enc.

September 27, 1976

Ms. Deborah Waddington
Bradley, Woods & Co., Inc.
733 Fifteenth Street, N. W.
Washington, D. C. 20005

Dear Debbie:

I enjoyed meeting you last week; I'm sorry things were so hectic. Thanks for sending along all the materials. I appreciate all your help, and I hope I was able to clear up the Governor's position a bit. For your information I'm enclosing our latest health position paper.

Thank you again for your help and concern.

Sincerely,

Bob Havelly
Health Issues Coordinator
National Issues & Policy

RSH/sw

Enc.

September 27, 1976

Dr. Jddson L. Hawk
3162 Piedmont Rd. N.E.
Atlanta, GA 30305

Dear Dr. Hawk:

I am writing to express my appreciation for all your help and support over the last several weeks, as I have been preparing briefing material for Governor Carter on preventive care and health policy generally. We have been fortunate to have the advice and assistance of knowledgeable people in important policy areas throughout the campaign, and I want to thank you and your colleagues for the time and concern committed to this effort.

The Governor will be using this material in the debates and elsewhere in his presentation of the issues. As I am sure you are aware, we are in constant need of further information in support of the Governor's commitment to effective primary and preventive care. Should you have additional ideas or data which may be of use, please be in touch.

Thanks again for your help.

Sincerely,

Robert S. Havelly
Health Issues Coordinator
National Issues and Policy

September 27, 1976

Harriette C. Bennett
720 N. Motor Place
Seattly, Wash. 98103

Dear Ms. Bennett:

Thank you for your letter of September 13. Governor Carter has forwarded it to me for my review as I will be in charge of health issues for the fall campaign.

Any further information or ideas you may wish to send along would be ~~more~~ helpful. Again, thank you for your help and support.

Sincerely,

Robert S. Havelly
Health Issues Coordinator
National Issues and Policy

September 13, 1976

The Honorable J. Carter
Democratic Candidate for President
Plains, Ga. 31780

Dear Sir:

Your campaign may gain some new information and ideas, regarding the Health Care issue, from the latest additions to my newly revised book.

I appreciate your "fortitude" in candidly speaking out on issues that need airing.

The people of this country need "inspiring leadership" at all levels of government, in business and in local communities.

I think that the majority of our citizenry are looking for a return to basic values - as found in religion, family life, etc.

What we desperately need is a "businessman" at the helm of the ship of state, so that the U.S. economy will not be financially bankrupted.

Keep up the fine work and God speed. (The Health Care additions are enclosed.)

Sincerely yours,



Harriette C. Bennett
720 N. Motor Place
Seattle, Wash. 98103

HCB: hb
Enclosures

Tel. 206 -633-1092

P.S. - I have an extra copy of the "manuscript" of the newly revised book, if you would like a copy. HCB

Dear Ms. Bennett:

Thank you for your
letter of September 13.

Gordon Carter has forwarded
it to me for my review
as I will be ~~back~~ in
charge of health issues
for the fall campaign.

Any further information or
ideas you may wish to
send along would be most
helpful. Again, thank you for your
help and support. Sincerely,

RSK
HEALTH ISSUES COORD.
NHTT ISSUES & POLICY

Bob Hawley



Carter - Mondale Presidential Campaign For America's third century, why not our best?

October 8, 1976

Mr. D. Eugene Sibery
Executive Vice President
Blue Cross Association
840 N. Lakeshore Drive
Chicago, Illinois 60611

Dear Gene:

I was delighted to have the opportunity to meet with you and other representatives of the Blue Cross Association on October 7. We have been wanting to meet you for some time and are delighted that we were able to have such a productive conversation.

I am very much looking forward to the assistance of Duane Carlson for the Governor's upcoming speech on the preventive health care and hope that we can count on your continued assistance in the days and months that lie ahead. I know that Bob Ball and Louise Weiner share with me great enthusiasm at the prospect of your assistance. Please know that we will be in contact with you again in the future.

Thank you again for your willingness to meet.

Sincerely,

Mary E. King
Advisor

1800 M. STREET, N.W. WASHINGTON, D.C. 20036 202/857-1600

Bob Havelly



Carter - Mondale Presidential Campaign

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

October 8, 1976

Dr. David A. Kindig, Director
Montefiore Hospital and Medical Center
111 East 210th Street
Bronx, New York 10467

Dear David:

Thank you for the copy of your letter endorsing the American Medical Student Association invitation for April, 1977. You are clearly aware of the unlikelihood of such scheduling at this time, but I appreciate your initiative.

Thank you for all the assistance you have given us and Joe Levin.

Plans are tentatively being laid for a speech by the Governor on October 19 at Miami, Florida before the Public Health Association. If the speech is finally scheduled, it will be concerned with what is usually called preventive health care approaches. I have on hand the materials you have submitted and am in the process of incorporating them into a substantive memo which will be used by the Governor in preparing his speech. However, if there are additional ideas or approaches or prayers or protests that you would make, please call me as soon as possible and let's talk about them on the phone. You may, in fact, want to put together a one or two page memo on the absolute elements you think must be addressed in such a speech. As I see it, the tone would be that the promise of America has always included good health as well as individual liberty and freedom from religious persecution -- that has included clean air, clean water, and sufficient food for good nutrition. And that we, as a nation, have lost sight of this promise of America in becoming sickness and disease oriented so that we no longer think of health.

Let me have your thoughts as soon as possible. They are deeply appreciated and always welcome. Don't wait to be asked.

Sincerely,

Mary E. King
Advisor

1800 M. STREET, N.W. WASHINGTON, D.C. 20036 202/857-1600

Bob Hawley



Carter - Mondale Presidential Campaign For America's third century, why not our best?

October 8, 1976

Mr. Alan K. Richards
Senior Washington Representative
Blue Cross Association
1700 Pennsylvania Avenue N. W.
Washington, D. C. 20006

Dear Alan:

Thank you so much for meeting with Bob Ball and Louise Weiner and me on October 7th. I found the meeting extremely productive and very useful and am indeed indebted to you for helping to arrange the discussion.

Please know that we will be in touch with you in the future and that we are counting on your continuing assistance as we move forward toward a more equitable national health policy and financing.

I am particularly eager to have your help in the area of prevention, as well as your continuing thoughts on preparation for National Health Insurance, cost and quality controls, and incentives.

Sincerely,

Mary E. King
Advisor

1800 M. STREET, N.W. WASHINGTON, D.C. 20036 202/857-1600

Bob Havely



Carter - Mondale Presidential Campaign For America's third century, why not our best?

October 8, 1976

Mr. George J. Kelley
Vice President
Blue Cross Association
1700 Pennsylvania Avenue N. W.
Washington, D. C. 20006

Dear George:

I am delighted to have had the opportunity to meet with you, Alan Richards, Gene Sibery, and Duane Carlson on October 7. This was an opportunity I had been looking forward to for some time. I'm delighted to know of your willingness to assist us and lend your support for the many areas that we discussed.

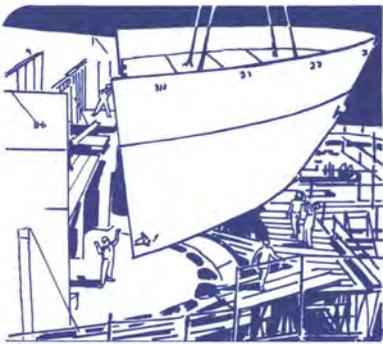
Please know that we will continue to count on you in the future and very much look forward to hearing from you on any further ideas you may have regarding preparation for National Health Insurance, cost and quality controls, and incentives.

Thank you so much for your willingness to meet.

Sincerely,

Mary E. King
Advisor

1800 M. STREET, N.W. WASHINGTON, D.C. 20036 202/857-1600



OCCUPATIONAL SAFETY AND HEALTH NEWS

Vol. IV

No. 3

INFLATIONARY IMPACT PAPER ON COKE OVEN STANDARD NOW AVAILABLE

On March 12, the U.S. Department of Labor announced the availability of its inflationary impact statement on the anticipated effect of recently proposed job health standards that would guard workers against the harmful effects of coke oven emissions.

Officials of the Department's Occupational Safety and Health Administration said the statement was prepared as required by President Ford's Executive Order 11821, issued November 29, 1974.

For recently issued standards proposals, such statements ordinarily will be made available 30 days before beginning public hearings on the proposed rules. Since the coke oven statement was not completed before hearings began November 4, 1975, a separate hearing has been scheduled to begin May 4 to consider the issues of inflationary impact, as well as technical and economic feasibility.

In addition to comments on inflationary impact, OSHA also announced it will receive testimony from the National Cancer Institute relating to whether existing information on workplace exposure to coke oven emissions indicates a safe exposure level. Due to the preparation time needed, NCI was unable to present its statement at the hearing that began November 4, 1975 and recessed January 8, 1976.

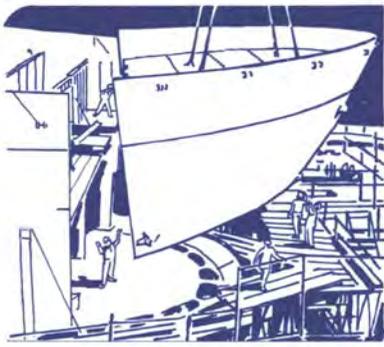
OSHA is particularly seeking comments on the following aspects of inflationary impact:

- Cost impact on consumers; businesses; markets; or federal, state, or local government.
- Effect on the productivity of wage earners, businesses, or government.
- Effect on competition, supplies of important materials, products, or services.
- Effect on employment and on energy supply or demand.
- Benefits to be derived from the proposed standard.

OSHA also is seeking information related to compliance with the proposed standards, including submissions on:

- The technical and economic feasibility of a performance standard, with or without engineering controls and work practice guidelines;

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OCCUPATIONAL SAFETY AND HEALTH NEWS

Vol. IV

July 1976

No. 5

OSHA ISSUES EMERGENCY DIVING RULE

The U.S. Department of Labor's Occupational Safety and Health Administration (OSHA) issued an emergency temporary job health standard to protect divers against the grave dangers they face on the job.

The emergency standard was published in the June 15th *Federal Register* and will serve as a basis for a proposed final rule.

The emergency standard became effective July 15th. An opportunity for written comments by the public and a hearing will be afforded before a permanent diving standard is issued by the agency.

Under the Occupational Safety and Health Act of 1970, OSHA may issue an emergency temporary standard when it has determined "that employees are exposed to grave danger from exposure to substances or agents determined to be toxic or physically harmful or from new hazards, and that such emergency standard is necessary to protect employees from such danger."

Dr. Morton Corn, head of OSHA, noted that OSHA believes a "grave danger" exists to divers. This belief is based on evidence gathered by OSHA in an earlier fact-finding hearing and on wide contacts with labor, with industry, and with technical, professional, and scientific groups.

According to Dr. Corn, OSHA found that diving is "inherently hazardous" and that there is a "total absence of any uniform and unforceable occupational safety and health standard to protect divers from such hazards."

"OSHA has also found that unsafe work practices exist in the diving industry," Dr. Corn said, "that have caused, and unless abated, will continue to cause serious injury, permanent disability and death among members of the diving community."

He added that, as a result of increases in diving activity in the search for additional energy and mineral resources, divers are now being exposed to increased health and safety risks. The use of deeper and longer dives, new operational modes and techniques, diving tables which have not been tested to the same extent as previously, and breathing mixtures augment the inherent high risk in the industry.

These factors constitute a grave danger, Dr. Corn said. Together with the inherent risk in diving, they make it necessary to issue an emergency temporary standard to

HEALTH INFORMATION DESIGNS, INC.

*James
Hamilton
Jordan*

September 27, 1976

Ms. Bonnie Barns
Carter-Mondale Headquarters
100 Colony Square
Atlanta, Georgia 30301

Dear Ms. Barns:

We are very anxious to help Governor Carter and Senator Mondale develop improved welfare programs during their administration. A friend of Hamilton Jordan, Owen (Scottie) Scott III, suggested that we relate some of our thoughts on the subject of Medicaid and Medicare problems to you to be forwarded on to Mr. Jordan and the Issues Committee.

We appreciate this opportunity to express some of our concerns in this area, and hope that should the Issues Committee desire any further information that they feel free to contact us.

Sincerely,

M. Lee Morse
M. Lee Morse, Pharm.B.
President

Aida A. LeRoy
Aida A. LeRoy, Pharm.D.
Vice President

HEALTH INFORMATION DESIGNS, INC.

Major problems in Medicare and Medicaid Programs in this country differ from state to state. Based on our experience, however, in designing quality control and fiscal control programs for Florida's Title XIX Medicaid Drug Program, and our exposure to Title XIX Programs in California, Arkansas, North Carolina, Pennsylvania, Maine, and Massachusetts, the following objectives appear to warrant a high priority in order to overcome the Country's general dissatisfaction and disenchantment with State and Federal welfare programs.

Fiscally-Oriented Objectives

1. Define uniform guidelines among the various State's eligibility procedures with a particular emphasis on routine eligibility updating.
2. Develop improved methods of provider reimbursement, maximizing State use of funds and providing an unencumbered cash flow (with quality control provision) to providers.
3. Develop a "central procurement" program goods and some services to maximize volume purchasing benefits and expand and improve the "HMO" concept of health care.
4. Design a program which allows for the sharing of fiscal responsibility in the form of capitation grants to nursing homes and hospitals providing an internal incentive to contain health costs (with the adoption of complementary quality control review programs) without compromising the level of health care.
5. Legislation involving generic prescribing and MAC/EAC must be completed in order to maximize benefits to recipients within controlled appropriations.
6. Develop a patient "lock-in" concept whereby the patient is restricted to his choice of primary physician, pharmacy, and hospital each fiscal quarter.

Quality Care-Oriented Objectives

1. Drug and Service utilization review programs must be strengthened and supported by various professional licensing agencies who are prepared to act on review recommendations.
2. Maximum monthly recipient expenditures must be established with provisions for awarding excess grants through prior

HEALTH INFORMATION DESIGNS, INC.

Page 2 of 2

authorization.

3. Establish realistic and therapeutically appropriate norms and therapy guidelines for medical services and drug therapy that are consistent with quality care as well as being fiscally manageable under present appropriation structures.
4. Decrease pharmaceutical manufacturers' impact on prescribing physicians, especially among those physicians who are identified as providing over 70% of their services to Medicaid/Medicare recipients.

**JIMMY
CARTER**

**WALTER
MONDALE**



Leaders, for a change.

November 1, 1976

M.L. Morse, President
Aida A. LeRoy, Vice President
Health Information Designs, Inc.
9645 Baymeadows Road
Suite 690
Jacksonville, Florida 32216

Dear Mr. Morse and Ms. LeRoy:

Thank you for your letter of September 27. Ms. Barns has referred it to me as I am handling health care issues on the staff level during the campaign.

I appreciate your interest in the problems of medicare and medicaid and the relevant materials you sent along.

Governor Carter shares your concern about quality and fiscal control of Federal programs; I am enclosing for your review two documents on these subjects which outline the Governor's philosophy.

Thanks again for your assistance and interest. Any further material you might wish to send would be appreciated.

Sincerely,

Robert S. Havely
Health Issues Coordinator
National Issues and Policy



HEALTH EDUCATION FOUNDATION

Watergate 600, Suite 452
600 New Hampshire Ave., Northwest
Washington, D. C. 20037

(202) 338-3759

Morris E. Chafetz, M. D.
President

October 14, 1976

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

Dear Bob,

When I submitted the draft position paper on Alcohol and Drugs, you invited me to submit any other things that might come across my way. The enclosed article written by a colleague of mine at the Johns Hopkins University may be of use.

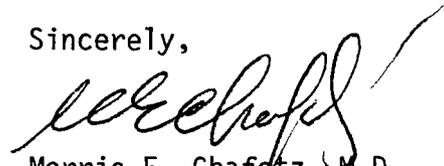
Also, in allaying the fears of the business community, Governor Carter is insufficiently emphasizing to them that he knows their world because he is a successful businessman himself.

I am looking forward to being invited to dinner at the White House.

Good Luck!

You have my best wishes.

Sincerely,


Morris E. Chafetz, M.D.

MEC/mcd

Enclosures

Dear Dr. Chafetz:

Thank you for your letter of October 14. I have forwarded Professor LAKSHMANAN'S material to Nick Helled, one of our foreign affairs specialists with experience in development aid programs, for his use.

Again, your material on alcoholism and drug abuse was most helpful, and we have used the information in two briefings on the subject for the President's Commission on Alcoholism and Drug Abuse. (over)

⑨ Thanks again for your help.

Sincerely,

Robert S. Havel,

Health Issues Coordinator

National Issues & Policy

Finley, Joanne E. M.D., M.P.H

57 Brookstone Dr.

Princeton, N.J. 08540

Phone 609-292-1838-39 (listed)

292-4010 (private)

Education: B.A. 1944 Public Adm. & Economics

Antioch College

Grad. Work American University - Economics / P.H.D.

M.P.H. 1951 Yale University School of Medicine

Experience: - New Jersey State Commissioner of Health / appointed by Gov.

- Director Public Health / New Haven, Conn.

- Deputy Commissioner (Medical) Cleveland, Ohio

- Visiting Lecturer, Rutgers University
(over)

- Associate - Public Health Adm. Case Western Reserve
- Publications, Research reports
- Consultant - area Public Health
- Appointed to head mission (ILO) to five Central American & Caribbean countries for family planning, 1964-68 White House Conference on Health (Invited post.)

CURRICULUM VITAE

JOANNE E. FINLEY, M.D., M.P.H.

PERSONAL DATA:

Residence: 57 Brookstone Drive
Princeton, New Jersey 08540

Mailing Address: New Jersey State Department of Health
John Fitch Plaza
P.O. Box 1540
Trenton, New Jersey 08625

Business Telephone: 609-292-7837-38-39 (listed)
609-292-4010 (private)

Married: Joseph E. Finley, Esq.
Attorney and Author

4 children

EDUCATION:

B.A. - 1944
(Highest Honors) Public Administration and Economics
Antioch College
Yellow Springs, Ohio

Graduate Work - 1945-1947 Economics, Public Administration
American University
Washington, D.C.

M.P.H. - 1951
(Highest Honors) Department of Epidemiology and Public Health
Yale University
School of Medicine
New Haven, Connecticut

Also

Departments of Sociology and Cultural
Anthropology
Graduate School -- 12 credit hours

EDUCATION (continued)

-2-

Certificate in Applied
Psychiatry for Allied
Professions (part-time
work 1947-1950, 1952-
1955)

Washington School of Psychiatry
Washington, D.C.

Courses in Organic
Chemistry and Physics
1955-1956

George Washington University
Washington, D.C.

M.D. - 1962

Case-Western Reserve University
School of Medicine
Cleveland, Ohio

Internship Certificate
(Pediatrics and
Adolescent Medicine)- 1971

Department of Pediatrics
Hospital of the Medical College of
Pennsylvania
Philadelphia, Pa.

PROFESSIONAL EXPERIENCE:

Present:
(Appointed by the
Governor, unanimously
confirmed by Senate and
sworn into office -
June, 1974)

New Jersey State Commissioner of Health

12/73 - 6/74

Director of Public Health,
New Haven Department of Health
New Haven, Connecticut

and

Lecturer - Health Administration,
Department of Epidemiology and Public Health;
Yale University School of Medicine
New Haven, Connecticut

12/72 - 12/73

Vice President, Medical Affairs,
Blue Cross of Greater Philadelphia, Pa.

and

Special Consultant, Pennsylvania Department
of Public Welfare (from Southeast Regional
Office of the Director of Health Affairs)
(Prepared Title XIX HMO Contract Guidelines;
Medical Care Quality Control Program)

PROFESSIONAL EXPERIENCE (continued)

9/68 - 11/72 Director of Health Planning,
Philadelphia Department of Public Health,
Philadelphia, Pa.
and

6/69 - 3/70 Staff Director - Mayor's Committee on
Municipal Hospital Services
and

3/70 - 2/72 Staff Director - Health Department
Task Force on Emergency Medical
Services for Philadelphia
and

7/71 - 4/72 Project Director: Experimental Health
Services Delivery System (contract between
Philadelphia Department of Public Health
and HEW-HSMHA)

6/66 - 8/68 Deputy Commissioner (Medical), and
Acting Health Commissioner - City
of Cleveland, Ohio, Department of
Public Health

also during same period: Project Director, Planning Project,
"Comprehensive Family Care Centers
for the Poverty Neighborhoods of
Cleveland" (OEO-CAP Agency Planning Grant)

then

Project Director - Hough-Norwood Family
Health Care Center (OEO 211-2 Grant)

3/63 - 6/66 Research Director - Cleveland Health Goals
Project (U.S. Public Health Service -
Community Health Services Grant to Cleveland
Welfare Federation, Health and Welfare
Council)

1956 - 1957 Executive Director (part-time) Parent and
Child, Inc. (parents pre and post-natal
education conducted with hospitals, Health
Departments, etc., in Metropolitan
Washington, D.C.)

1955 - 1956 Executive Director - Montgomery County,
Maryland Planned Parenthood League

PROFESSIONAL EXPERIENCE (continued)

1952 - 1955 Health Education Director
Montgomery County TB and Heart
Association

Field training supervisor, graduate
students; Department of Sociology,
University of Maryland

Summer 1950 Special education counsellor 5-6 year
old boys, Camp To-ho-ne
Great Barrington, Massachusetts

1949 - 1950 Public Affairs Analyst; writer
National Committee for an Effective
Congress; Washington, D.C.

1948 - 1949 Field Director - National Institute
for Social Relations (Washington, D.C.)
Muncie, Indiana Project

1945 - 1948 Administrative Assistant; Hon. George
E. Outland, U. S. House of Representatives,
Washington, D.C. and Campaign Manager, 1948;
Santa Barbara, California

1944 Research Economist:
Office of Alien Property Custodian,
Washington, D.C.

TEACHING APPOINTMENTS:

Present: Visiting Lecturer, Department of Community
Medicine, College of Medicine and Dentistry
of New Jersey, Rutgers Campus

1974 Yale University School of Medicine,
Department of Epidemiology and Public Health,
New Haven, Connecticut
(See Professional Experience)

1969 - Present Assistant Clinical Professor and Visiting
Lecturer; Department of Community and
Preventive Medicine
Medical College of Pennsylvania

TEACHING APPOINTMENTS (continued)

1967 - 1968

Associate - Public Health Administration,
Department of Preventive Medicine;
Case Western Reserve University
School of Medicine, Cleveland, Ohio

Fall 1960

Student teaching and laboratory assistant
to "Nervous System Committee" (Neurology
and Neuropathology) Western Reserve
University School of Medicine

1948 - 1949

Instructor, Summer Institutes in Community
Leadership and Community Organization;
George Washington University, Washington, D.C.

LICENSURE AND BOARD CERTIFICATION:

Diplomate, American Board of Preventive Medicine (Public Health), June, 1972.

Medical Licensure:

New Jersey	#30431 (July, 1975)
Connecticut	#16472 (January, 1974)
Pennsylvania	#011385E (Spring, 1969)
District of Columbia	#2428 (September, 1964)
Ohio (by written examination)	#26278 (January, 1963)

National Board of Medical Examiners - Parts I. and II. (Candidate #75576)

PUBLICATIONS, THESES, RESEARCH REPORTS:

The Impossible Troika: Technology vs Society vs Individual Rights:
(Implications of the findings of the New Jersey Supreme Court in
re Karen Quinlan). To be presented, 104th Annual Meeting - American
Public Health Association, October, 1976, Miami Beach, Florida.
Panel: "What Price Life."

Planning and Regulation: A Strategy to Encourage Preventive Care:
Paper to be presented, 104th Annual Meeting - American Public Health
Association, October, 1976, Miami Beach, Florida. (Co-authors:
Wagner, David A., M.S.; Reiss, John B., Ph.D.).

Out of the High Costs Crucible: Making Medical Care Evaluation Work;
delivered at the 101st Annual Meeting - American Public Health
Association, November, 1973, San Francisco, California.

Planning for Urban Emergency Medical Services: - delivered 100th
Annual Meeting, American Public Health Association, November, 1972,
Atlantic City, New Jersey; scheduled for publication in the American
Journal of Public Health (Co-author, Hamilton, William F., Ph.D.).

University - Municipal Government Cooperation in Health: (with Cotton,
Mary, and Hamilton, William F., Ph.D.) - delivered 100th Annual
Meeting, American Public Health Association, November, 1972, Atlantic
City, New Jersey.

Report of the Mayor's Committee on Municipal Hospital Services,
Philadelphia, Pennsylvania, February, 1970.

Pennies, Priorities, and People Pressures: Can Planning in an Urban
Health Department Help?; American Journal of Public Health, Vol.60,
#7, June, 1970.

Cleveland, Ohio, Health Goals Project:

1) Greater Cleveland and Its Health

- a. Demographic Analysis of Cuyahoga County;
- b. Health Status Study;
- c. Expenditures for Health Care - Public and Private.

2) Profiles of Existing Community Health Services, Facilities and Resources in Greater Cleveland

Labor and Delivery: The Birth of a Neighborhood Health Center;
Case-WRU Medical Alumni Bulletin, November, 1967

The Effect of Epinephrine on Uterine Contractility in Human Labor;
Thesis, Western Reserve School of Medicine, 1962

The Epidemiology of Mental Disorders; Master's Thesis, Yale University,
Department of Public Health, 1951

Student Research Assistant to Professor August Hollingshed and Dr. Fritz Redlich in data collection in Connecticut State Institutions and private psychiatric clinics - for their publication - Social Class and Mental Illness, Winter-Spring 1950-1951

Watching Washington - By-line weekly column for Ohio Labor Press Associates, 1946 - 1948

Food Costs More in Harlem - Paperback book on results of a food prices and food quality research project conducted for national NAACP, and assisted by the U.S. Office of Price Administration, and the U.S. Department of Agriculture, 1943.

PROFESSIONAL MEMBERSHIPS:

Association of State and Territorial Health Officers (1974- present)
American Public Health Association, Medical Care Section
Philadelphia County Medical Society (to 1974)
American Society for Public Administration
Board of Directors, Executive Committee, Fair Housing, Inc.
Cleveland, Ohio
Academy of Medicine of Cleveland and Cuyahoga County, Ohio (to 1968)
U.S. Conference City Health Officers (1966-1968, 1974)

BOARDS AND COMMISSIONS:

(The list is not inclusive; only major responsibilities are given.)

Board of Trustees, College of Medicine and Dentistry of New Jersey
(ex-officio)
Chairman, (by Statute by virtue of office) - New Jersey Health Care
Facilities Financing Authority
New Jersey Health Care Administration Board (voting member, by statute)

BOARDS AND COMMISSIONS: (continued)

New Jersey State Health Coordinating Council (ex-officio)
Board of Institutional Trustees, New Jersey Department of Institutions
and Agencies (includes Medicaid Program)
New Jersey Departments of Higher Education and Health and
College of Medicine and Dentistry of New Jersey - Council on
Post-Graduate Medical Education
Board of Directors - New Jersey Cancer Institute
Chairman, Subcommittee on Public Health Education, of the Council
on Health Professions Education, Department of Higher Education

CONSULTATION:

1975 - Present Council on Education for Public Health, accreditation
(Schools of Public Health) site visiting team.

1974 Board of Directors, Professional Examination Service
New York City

1972 - 1974 Commissioner: Commission on Education for Health
Administration (Kellogg Foundation), Washington, D.C.

1972 - 1973 Health Systems Consultant: Philadelphia Bicentennial
Planning Group - now Philadelphia '76 Corporation.
(Prepared special emphasis health theme for
Philadelphia, 1976, plus plan for emergency health
care of American and foreign visitors).

 Regional Comprehensive Health Planning Council, Inc.
(five counties, southeastern Penna.) - Member:
Facilities Review and Study Committee

1971 Southern Michigan Council of Governments (for 6
County Health Departments) - Planning Techniques
and Consumer Involvement.

 Columbia University School of Public Health and
Administrative Medicine - continuing education
series; Philadelphia area workshop (faculty)

 also appointed to head ILO mission to five Central
American and Caribbean countries to develop and
implement ILO participation in family planning
and maternal health programs for plantation and
industrial workers. Mission was never conducted
for financial and political reasons.

CONSULTATION: (continued)

1970

Workshop: University of Tennessee, Department of Preventive Medicine, with West Tennessee Regional Medical Program and Memphis-Shelby County Department of Public Health. Public Agency Roles in Planning.

Greater Delaware Valley Regional Medical Program - grant applications review.

1966 - 1968

Health Commissioner's Advisory Committee to Ohio Department of Public Welfare (on Title XIX health services guidelines, including eligibility of public health medical care programs for reimbursement)

Ohio Department of Public Health - Ad Hoc Committee on Local Health Departments System (Reorganization and Legislation)

Surgeon General's Conference on Urban Health Problems - invited participant.

1964 - 1968

Mental Retardation Services Planning Committee, Cleveland, Cuyahoga County, Ohio

1964 - 1968

White House Conference on Health - invited participant.

SPECIAL PROJECTS:

October, 1975

By joint invitation - Fogarty International Center, NIH and Swedish Government: participated in two week training seminar: Health Care Delivery System in Sweden (Stockholm, Linköping, Skara, Skövde, and Motala, Sweden).

H. OBER HESS
FREDERIC L. BALLARD
M. CARTON DITTMANN, JR.
BOYD L. SPAHR, JR.
THOMAS G. B. EBERT
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EDMUND L. HARVEY, JR.
HELEN P. PUDLIN
VINCENT P. HATTON
DAVID F. SCRANTON

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MORRIS CHESTON
SHERWIN T. McDOWELL
D. ALEXANDER WIELAND
JOHN BEDFORD KING
COUNSEL

June 25, 1976

Honorable Jimmy Carter
Plains, GA 31780

Re: Joanne E. Finley, M.D. and PhD.
State Commissioner of Health
State of New Jersey

Dear Jimmy:

I have had the opportunity in recent years to work with Dr. Joanne E. Finley, whose professional status and title is given in the caption above. As bond counsel for the financing of hospital construction in the State of New Jersey, I got to know Joanne as a public official devoted to the cause of good government and in particular the efficient and enlightened delivery of health care. Recently, when I mentioned my interest in your candidacy to her, I found that she was eager to work in your campaign as an advisor, researcher and speech writer in the health policy and health program areas. Joanne does not expect to be paid but, with the anticipated blessing of Governor Byrne, would find room to do work on your behalf on her own time.

I got from Joanne and enclose a copy of her curriculum vitae from which you can see that her entire career has been in public service as an economist and later as an administrator of public health at the county, city and ultimately state levels where her recent emphasis has been on health care financing including reasonable cost containment methods and development of programs of preventive medicine. Her career includes congressional experience.

Now for a personal appraisal. Joanne Finley for over three years has run the New Jersey health program which is at the forefront of this country's delivery of health care at the

Honorable Jimmy Carter

-2-

June 25, 1976

state level. It has not been an easy assignment. She has implemented a comprehensive health planning program to include budget review and rate setting in a way that promises to be a model for state programs throughout the country.

Joanne advises me that other persons of distinction in the health or education fields are or may be involved in your campaign who would remember her and could recommend her participation. Dr. Harvey Sloane, presently Mayor of Louisville, Kentucky, and New Jersey's Chancellor of Higher Education would be references. Ted Sorenson would recall Joanne and her husband from pre-Kennedy days.

I took the liberty of sending this directly to you because I have genuine admiration for the work that Joanne Finley has done in the public health service and I am sure that she could bring much talent to bear for your benefit in this nationally important and controversial field.

I talked the situation over with Jack Sullivan and he felt that I ought to send this recommendation on to you direct.

Best personal regards to you and your family.

Sincerely,


Joseph P. Flanagan, Jr. *NA 47*

JPF, Jr/hh
cc: Jack Sullivan

Foundation for a Future

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Executive Director

CONTACT:
Laura Shields
(213) 332-5234

AVAILABLE FOR INTERVIEW - DR. JOSEPH W. STILL, MD, MPH

Physician - Scientist

- Executive Director, "Foundation For a Future", a non-profit organization dedicated to acquainting the public with significant but little known facts necessary to advance health, longevity, and general welfare.
- Diplomate, American Board of Preventive Medicine and Public Health.
- Author of "The Cybernetic Theory of Aging".

The Issues:

1. Our country spent an astronomical \$118 billion on so-called Health Care last year. The greatest part of this money was spent not on Health Care, but for Disease Care. We are trying to do the impossible: cure degenerative diseases *in a population whose average length of life is constantly increasing.* If we are ever to shift the emphasis of medical practice from treatment of disease to prevention of disease, we must stop confusing medical and surgical treatment of disease with Health Care. A fact that is little known.
2. Degenerative diseases such as arteriosclerosis, diabetes, strokes, heart attacks, cancer, kidney diseases and osteoporosis can be prevented. A few physicians pioneering in the newly-developing field of Personal Preventive Medicine are helping their patients to do this. A fact that is little known.
3. The aging process can be slowed down, in some cases even reversed and thus the middle years of good life extended. A fact that is little known!
4. The level of cholesterol in our bodies probably depends more on the amount of thyroid in the blood than on the amount of cholesterol and other fats we eat. A fact that is little known!

5. Overweight, hypertension, and hypoglycemia are pre-disease conditions, not diseases. They are a sign of premature aging and often indicate that the endocrine system is out of balance. Correcting the endocrine imbalance will often overcome and control these pre-disease conditions. A fact that is little known.
6. Hypoglycemia is generally considered the opposite of diabetes. That is not true. Hypoglycemia is a condition that will develop into diabetes if neglected. A fact that is little known!
7. There are effective, but generally little used, ways of combating several other less common pre-disease conditions. A fact that is little known.

What Dr. Still has to say about the issues:

1. "Hundreds of thousands of Americans suffer needlessly and die prematurely of a number of degenerative diseases because they are not receiving the kind of Personal Preventive Medical care that can greatly reduce the chances of developing one or more of the degenerative diseases from which more than three out of four Americans now die.

"Medical science does not yet have all the answers...but we do have enough knowledge to do a great deal more than we are doing to prevent degenerative disease. Unfortunately much of the knowledge we already have is not being widely used.

"The medical profession has not placed its emphasis on preventive medicine. It cannot because it is primarily dedicated to the treatment of disease. We must recognize that the philosophies and techniques of personal preventive medicine are entirely different from those required of physicians who treat diseases. If adults are to have the same kind of high quality preventive services that pediatricians provide for children, a new profession, with its own schools and research institutions, must be established...the profession of Personal Preventive Medicine.
2. "The widespread application of existing knowledge in the practice of Personal Preventive Medicine would result in the following:
 - a. A substantial increase in the average length of life.
 - b. A substantial decrease in the number of physicians needed to treat diseases.
 - c. A substantial reduction in the number of hospital beds needed to treat diseases.
 - d. A substantial reduction in total medical and health costs, as well as a reduction in pain and suffering and increased efficiency and production in our economy.

- e. Probably a considerable reduction in the amount of invalidism and in the length of the period of senility that too commonly precedes the death of older people.
3. "Aging per se does not destroy us. It is the degenerative diseases which occur with increasing frequency with advancing age, that destroy our bodies in a variety of ways. Most of these ways are associated with breakdowns in one or more parts of the nervous-endocrine (or Cybernetic) system which controls the function of all of the trillions of cells that form our bodies. To some extent we are able to control the aging process by countering early deficiencies or abnormalities in the nervous-endocrine system before full-blown irreversible disease has developed.
4. "The controversy over whether or not to eat eggs and other saturated fats is heating up again. I want to be numbered among those who feel it is a great blot on science that so much time and money is being spent researching chloolesterol levels and the relationship of diet to the occurrence of heart attacks, when we already know how frequently people suffering from high blood pressure and high levels of chloolesterol and other fats in the blood can be cured by merely correcting the thyroid deficiency from which many of them suffer.
- "A basic fact that has been reported in medical literature for years has been almost universally ignored. In many if not most cases the level of chloolesterol and other blood fats in our bodies depends more on the amount of thyroid in our blood than it does on the amount of chloolesterol we eat.
5. "Efforts to control weight by diet and exercise alone ignore the basic medical facts and encourage overweight people to neglect the most common basic problem...endocrine imbalance. A good balanced diet is important and so is the right amount of the right kind of exercise...but unless endocrine imbalances are permanently corrected, other efforts will give only temporary results."
6. "There are millions of hypoglycemics in this country. Many are overweight and miserable. They will become diabetics in later life unless their hypoglycemia is brought under control and maintained under control for the rest of their lives by a program of Personal Preventive Medicine."
7. Many other less common pre-disease conditions can be successfully controlled by various techniques.

More about Dr. Still:

Both physician and scientist, Dr. Still's entire professional life has been concerned with the prevention of diseases that affect the greatest number of people.

During the second World War, Dr. Still served as Assistant Chief of Preventive Medicine in General Eisenhower's North Africa (later called Mediterranean) Theater of Operations. As an epidemiologist and administrator he assisted in the development and operation of a variety of programs designed to control and prevent malaria, typhus, diarrhea, dysentery, plague, sandfly fever, venereal diseases, accidents, etc. He was involved in the early planning and development of programs which used DDT to control and virtually eradicate a number of these diseases which are generally spread by insects.

For two years after WW II he served as a Health Officer in Virginia and then began a nine year stint of research and teaching at George Washington University Medical College. His research focused on discovering the cause of aging. In 1956 he published the Cybernetic Theory of Aging. Now 20 years old, it has become one of the leading theories. It may be considered to be the General Theory of Aging while most others are special theories...Cross-linkage, Mutation, Immunity and Stress Theories. None of these are incompatible with the Cybernetic Theory.

For the past twelve years Dr. Still has been practicing Personal Preventive Medicine, with emphasis on the elimination or control of the conditions that lead to the degenerative diseases.

Dr. Still is the author of two books and of many articles for professional journals and general magazines.

A Pasadena resident, Dr. Still is available for interview on radio, television, and with the press.

#

Joseph W. Still, M.D., M.P.H.

6/19/76

1408 Edgecliff Lane
Pasadena
California 91107

Dear Mr. Havely -

It was good to receive your June 15th letter. I'll enclose a copy of my April 3, 1976 to Mr. Kolbey. This is the third copy I've sent in the hope of being able to contribute to the planning especially with regard to Personal Preventive Medicine. I surely hope this reaches you.

I've reread my April 3rd letter & only want to add these remarks -

1. The recently formulated "Available for Interview" release outlines the philosophical & practical position I've readed. I'm confident that this is the goal that most people who say they want more "preventive medicine" vaguely have in mind. However,

2. Because the Medical Establishment,

which is almost exclusively devoted to doing basic research on the cause of the degenerative diseases or R&D work to help the clinical professors develop artificial hearts, kidneys & pancreases etc., also controls most of the research money it is virtually impossible to get Personal Preventive Medicine off the ground.

3. The few physicians who are practicing various aspects of this ^{that is based on a firm scientific base} kind of medicine are so scattered that we find it difficult to communicate. Finally,

4. Because of the attitude of the Establishment & because there are a good many people who claim to be practicing preventive medicine with techniques of doubtful validity I believe that - after Mr. Carter becomes President - a small scale model of a Personal Preventive Medicine program should be established here in So. Calif. If it proves successful, as I'm

Joseph W. Still, M.D., M.P.H.

2037 Rodney Drive
Los Angeles, Calif. 90027
Phone (213) 663-5106

sure it will, the idea can then be fairly rapidly extended to the rest of the country.

In order for you & others on Mr. Carter's staff to be assured that I'm not talking through my hat, I'll be glad to spend a good deal of time discussing some of my patients (in their presence) with a few people who would be shown the factual foundation for the statements made in this letter & other papers attached.

After you've had an opportunity to go over this material I'd appreciate having an opportunity to talk to you by phone. If you'll call me at home, about 8:00 AM (P.D.T.) on Mon or Tues. or any evening after 7:00 PM (P.D.T.) and reverse the charges I'll be available. Sincerely,
JW Still

Please excuse the handwritten
letter. I send it this way to save
time as it's written over the weekend.

JWS



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PHILOSOPHY AND GOAL

The Foundation was formed in the belief that a number of important problems that have faced the American people for many years should by now be non-problems. That is, essential facts and ideas needed for at least partial solution of these problems are known. But because of inadequate social institutions these facts and ideas are known by and of interest mainly to researchers. These ideas need to be translated into workable programs of adequate scope and be provided by sufficient numbers of people to make a real impact on these problems.

One of these problems is in the field of medicine. For more than forty years, Congress and the American people have been debating the question of whether or not to socialize the distribution of medical and hospital care for the treatment of diseases. But while this debate droned on, the problem itself changed. The diseases that were most common when the debate began (contagious, infectious and parasitic diseases) have been eliminated as major causes of disability and death. Now the principal causes of disability and death are the degenerative diseases.

Forty years ago polio, diphtheria, scarlet fever, smallpox, rheumatic fever, meningitis, malaria, pneumonia, tuberculosis, streptococcal and staphylococcal blood poisoning, hemorrhage and the like were major causes of death. Today, advances in medical science and practice have largely eliminated these diseases. The result is that now most newborn babies can be expected to reach middle age without having any of these afflictions. So now most babies can expect to become middle aged and to develop one or more of the degenerative conditions that become increasingly common after about age thirty. To prove that aging begins in the thirties, notice how rarely professional athletes can continue active beyond the mid-thirties. When their legs and reflexes begin to slow down they are "over the hill".

The great increase in the percentage of people now surviving to join the "over the hill" group has, of course, resulted in a very great increase in degenerative diseases, and medical scientists are now busy trying to unravel the mysteries surrounding the physical and chemical causes of these diseases, the

most common of which are cancer, diabetes, arthritis, arteriosclerosis and high blood pressure - the basic causes of most heart attacks and strokes. But science is still a good distance from total victory over any of the degenerative diseases, and very little effort is being directed toward utilizing existing knowledge to counter the early degenerative changes that slowly progress during the middle years of life.

Nevertheless, it already is well established that three factors - excessive stress, breakdowns in the nervous - endocrine system and poor nutrition - play major roles in the development of degenerative diseases. And a small but growing number of physicians are using this knowledge in preventive ways to delay and even in some cases to reverse early degenerative processes before they become irreversible.

The Foundation For a Future hopes to make this knowledge and the physicians who are using it better known to the American people. And to assist in the organization of programs of sufficient scope to provide this newly possible form of medicine on the scale its importance warrants. Success in this effort will not only substantially increase the years of healthy middle age, but we believe it will also greatly diminish the amount of senility and invalidism that is presently occurring to too many older people.

It is the great increase in this kind of illness which has caused a number of former advocates of total National Health Insurance to have second thoughts. The Foundation believes that we do need a national system of insurance to protect people of all ages against catastrophic accidents and illnesses. But it also believes that it would be the height of foolishness to subsidize a steady increase in these diseases by failing to establish the widespread practice of Personal Preventive Medicine. A small fraction of the money now being spent for treating degenerative diseases could, we believe, produce very large reductions in the amount of invalidism that occurs to people in the second half of life. That, of course would result in greatly reducing the total cost of medical care in our country and greatly reduce human suffering as well.

SPECIFIC ACTIVITIES

- (1) To acquaint the general public with significant unused information and ideas of potentially great value for advancing the health, longevity and general welfare of our society and, especially, to make publicly known the fact that aging can be treated as a preventable or even, in some cases at least, a reversible condition.
- (2) To develop, in certain instances, model programs to provide new types of preventive health services that will make manifest the practical value of this information and/or ideas, hopefully leading to the replication of the model by others.
- (3) To acquaint the public with the names and practices of individuals and institutions which are pioneering in the development of Personal Preventive Medicine.
- (4) To conduct, and encourage others to conduct, research in areas where significant knowledge gaps are discovered.
- (5) To encourage physicians and other health personnel to enter this important new medicine of the future.
- (6) To raise money from the general public as well as from other foundations to be used in furthering the five previous purposes.

WHAT CAN YOU DO?

- (1) Join the Foundation For a Future
- (2) Get others to join and
- (3) Become a volunteer worker.

WHAT CONTRIBUTORS RECEIVE

Bulletins informing members of the Foundation about medical and scientific developments of interest, as well as progress in reaching the goals outlined above.

* * * * *



THE CYBERNETIC THEORY OF AGING

JOSEPH W. STILL, M.D., M.P.H.

PERSONAL
~~ADULT~~ PREVENTIVE MEDICINE: THE FOURTH PHASE
IN THE EVOLUTION OF MEDICINE*



JOSEPH W. STILL, M.D., M.P.H.†

ABSTRACT: Adult preventive medicine is the presently emerging phase of scientifically based medicine. This article: 1) traces the necessity for the development of adult preventive medicine because of many social mutations that have taken place in this century, and 2) outlines its theoretical foundations, involving such matters as health education and adult preventive medicine programs (medical weight control, anti-smoking, preventive endocrinology, health education in human physiology and how to cope with stress, potential and motivational analysis, and predictive physico-chemical programs).

The role of the physician will change from that of a supervisor of detection-treatment medicine to that of an advisor and consultant in adult preventive medicine. Computerized pre-disease diagnosis and health education (including knowledge concerning the use and abuse of stress) will be emphasized, to improve upon the present history-and-physical-examination method.

The total program will require a tremendous increase in professionals trained to manage its various aspects.

In the 500-year history of modern scientifically based medicine, three distinct phases are apparent:

Phase I: *Mass Preventive Medicine or Public Health Sanitation*

Phase II: *Diagnosis and Treatment of Disease and Injury in Individuals*

Phase III: *Rehabilitation to Maximal Potential of Persons Recovered from Serious Disabling Disease or Injury*

Phase IV: *Adult Preventive Medicine*, is now clearly emerging. Its goal is to provide adults with the same kind of high-quality, scientifically sound preventive services that pediatricians provide for infants and young children. In recent months, there has been growing recognition that adults are not now receiving the full benefits of existing medical and scientific knowledge. This knowledge can be used to detect at early stages, to delay, and even sometimes to prevent many disabilities and diseases that now afflict adults.

* Presented at the Meeting of the International Society for Comprehensive Medicine, September 1967.

† Address: 1408 Edgecliff Lane
Pasadena
California 91107

April 3, 1976

Mr. John Kolkey, Issues Coordinator
Carter for President
8727 W. Third Street
Los Angeles, Calif. 90048

Dear Mr. Kolkey:

As I told you, I have spent my entire professional life in one aspect or other of preventive medicine - about a third in mass preventive medicine (5-1/2 years in the Army Medical Corps and six years in three different city, county and state jobs); about a third teaching and doing research on aging and the degenerative diseases at George Washington University Medical School. The principal result of this work was the invention of the Cybernetic Theory of Aging and of what I then called Preventive Geriatrics (I attach two more recent updates of those original papers). The most recent third has been spent in the practice of what I now call Personal Preventive Medicine.

These twelve years of treating several thousand patients who were suffering from one or more of these conditions - overweight, hypertension, hypoglycemia, diabetes, arteriosclerosis, psoriasis, osteoporosis, arthritis and a few more much less common degenerative conditions - have made it abundantly clear that a very large percentage of these conditions are caused by endocrine, metabolic and nutritional disorders which the vast majority of disease-oriented physicians are ignoring, partly no doubt for the reason that they are so busy treating people who are acutely ill from diseases and traumas which carry a high level of malpractice risk. I enclose a short paper recently distributed to my patients in order to make them aware of the real value of the kind of weight control program we offer. Recently I've also written a much longer paper, for delivery to the annual meeting of the California Osteopathic Society, which spells out this argument in more detail. If you would like to see it, I'll be glad to send a copy so you'll know that I'm not talking about ideas which are solely my own. There are a few hundred, perhaps a few thousand, physicians in the

United States practicing various aspects of this kind of medicine. Because they get no support from the disease-oriented medical establishment, which has a virtual monopoly on all medical research money, there is no organization to pull them together into an efficient lobby. In an effort to begin this process some of my friends have helped me found the Foundation For a Future (copy attached) which has just begun to operate, in December. We are making progress but of course slowly.

A second reason that most doctors do not practice preventive medicine is that the basic skill required for practicing preventive medicine - mass or personal - is the skill of communication. It seems to me that many doctors aren't very good at that and, besides, their fear of lawsuits causes them to be reticent about talking to patients.

Because of my background in large-scale organization and administration and my knowledge of quite a few of the scattered elements that we need to unite and coordinate in order to produce a fully developed new kind of medicine, personal preventive medicine, I believe I have the clearest view of anyone in this country of how to go about this. I am even now trying to create a small scale model of this kind of medicine in Southern California.

One more point. If my estimate of the numbers of Americans now suffering from various kinds of pre-disease conditions, which when corrected make for vastly improved health and of course reduced illness and delayed senility, is correct, the number is at least 50 millions. Organizing this kind of medicine will not only add greatly to the personal well-being of these people but it will also greatly reduce the costs of treating the serious sequelae - heart attacks - and this should add substantially to increased productivity in our economy. If these estimates and opinions are correct, the organization of Personal Preventive Medicine would add a great new industry to our society, one which can be largely if not entirely self-supported, once a model is available and its worth proven.

Mr. Kolkey

April 3, 1976

page three

If you are interested in more details, please ask for them.

Sincerely,

Joseph W. Still, M.D., M.P.H.

JWS:hc
enclosures

Reprinted from a recent edition of AMA News.

other opinion

The case for preventive medicine

Philip H. Abelson in Science:

Private and government expenditures for health are now devouring a substantial part of the gross national product. In spite of considerable evidence that the health care system is not cost-effective, the prospect is for continued growth. In 1950, funds spent for health were \$12 billion. In 1975, they reached \$118.5 billion.

Until 1965, the government spent only nominal amounts for health care. With the advent of Medicare and Medicaid, the federal treasury became an engine of inflation of health costs. Federal expenditures rose rapidly to \$34 billion in 1975, and this led to enhanced costs for the private system also.

Articles have appeared in which authors seek to identify specific causes for the increase—for example, soaring hospital costs. For the most part, they miss the main point.

WHEN THE MAJOR FRACTION of medical costs is borne by a third party, demand for care is practically infinite. Patients urgently seek treatment, even surgery, on the basis of trivial symptoms. Distraught relatives hope to prolong the lives of moribund loved ones. Fearing malpractice suits, many physicians practice medicine defensively, ordering more tests and procedures than they otherwise would.

The public assumes that large expenditures for health care will bring better health. This assumption is questionable. During the early part of this century, life expectancy in the United States steadily increased, but it reached a plateau in 1954. In 1967, W. H. Forbes explored the relation between national expenditures in behalf of health and actual results. He concluded that we could halve or double the total expenditures without changing longevity. This was in a year when only \$42 billion was spent.

Since 1967, others have pointed out that most of

the deaths in the age range 10-70 either are due to degenerative diseases or are fatalities arising from accidents, suicide, or homicide. The big killers are coronary heart disease, cancer, and stroke. Treatment of these diseases is often costly. Their incidence is related in part to lifestyle, for example, sedentary living, poor diet, obesity, smoking.

BECAUSE TREATMENT of degenerative diseases is not uniformly successful and since the course of some of them can be altered by changes in the patient's behavior, there is increasing interest in preventive medicine. Frederick C. Swartz, MD, has stated that "our greatest health problem is in the physical fitness of the nation. Here the answer is the simplest and the cheapest, has the greatest application, and its reflection on the reduction of morbidity and mortality rates would be immediate and tremendous. It is entirely possible that a well-practiced physical fitness program begun early in life would increase life expectancy by 10 years . . ."

Studies seem to show that longevity depends on a combination of factors. Prominent among them are good nutrition, weight control, abstention from excessive drinking of alcohol and from cigarets, and getting enough exercise and sleep. Faced with the prospect of giving up smoking and engaging in vigorous exercise, many people would just as soon take their chances.

HOWEVER, OTHERS would like to pursue a more prudent course. They would be encouraged to do so if they had specific information about the effort required to increase their life span.

Substantially better health cannot be bought with \$118.5 billion. Isn't it time the nation began to pay more attention to approaches that promise great improvement at little cost?

Important Cont. / / / /

Ditto

4 AMERICAN MEDICAL NEWS • JUNE 14, 1976

* Though exercise improves fitness, I believe there is no evidence that it prolongs life. I believe I can clearly prove from my patients that I am - by endocrine replacement and education re stress - able to substantially increase their life spans. I hope you'll be interested in having someone

Though this paper relates to Mass Preventive Medicine, in publishing it, it treats one disease beginning to prove that the banning of DDT was a serious mistake - a mistake made on political rather than scientific grounds. San Francisco Examiner

The Amazing Facts About DDT



Saturday, March 20, 1971

Page 9



Dr. Joseph W. Still earned his medical degree at Nebraska University. He received his degree in Public Health at Johns Hopkins. Doctor Still has been in professional practice for more than 30 years and was involved in the first uses of DDT to protect the lives and health of American military men during World War II. As a recognized expert, Doctor Still of West Covina, recently addressed the California State Water Quality Control Board in Los Angeles. This article reflects the main thrust of his address.

By Dr. Joseph W. Still

Master of Public Health and Preventive Medicine

I AM APPALLED by the illogical, unscientific, inhumane and sometimes even dishonest and certainly insane campaign which has been carried on against DDT.

I use the word "insane" in the correct psychiatric sense: Ideas which are essentially unrelated to the realities concerned. A campaign which almost all the news media and many supposedly liberal and humanely oriented lay journals have joined on a pure knee-jerk basis.

I say "knee-jerk basis" because when viewed in proper perspective, the facts in no way justify the fears engendered. The media simply parrot and amplify scary claims and charges that they made

no attempts to check. Lest someone assume I have a financial or professional

stake in the future use of DDT, it may be well to state that:

(a) I have no financial or professional ties with any company producing or selling DDT or any other chemical or drug;

(b) Since 1946, when as a Lt. Colonel I completed a five-and-one-half year tour in the U.S. Army Medical Corps, I have had no professional or business dealings whatsoever with DDT or any other insecticide.

My reasons for making this statement are:

1. I believe the most socially damaging thing that can be done is to mislead the American people and frighten them with grossly false charges.

2. The anti-DDT campaign threatens to return the peoples of Asia, Africa and Latin America to the terrible state of ill health they suffered before DDT. In those days — because of the widespread prevalence of malaria, typhus, yellow fever, plague, dysentery, sleeping sickness and other deadly diseases — the average length of life ranged from 20 to 30 years in most of the countries on the three southern continents.



SPRAYING inside Indonesian house for mosquitoes. Wall and bed are made of bamboo.

—Photo courtesy Center for Disease Control, U.S. Public Health Service

3. Different committees of highly qualified scientists have made independent studies in the last seven years of the alleged hazards of DDT. These committees include:

- The President's Advisory Committee.
- The Environmental Pollution Panel of the President's Science Advisory Committee.
- The Committee on Persistent Pesticides of Biology and Agriculture of the National Academy of Sciences.
- The HEW Commission on Pesticides and Their Relationship to Environmental Health.
- The Council on Occupational Health.
- The Council on Environmental and Public Health of the American Medical Association.

Crucial Point

Not one of these groups has recommended banning DDT, because all have recognized that for many purposes there are no substitutes as effective, as cheap, or as safe as DDT.

But some of the so-called environmental protectionists — aided by a few scientists with limited credentials — have not been satisfied with these decisions. They have gone ahead and made an ever-shifting series of unfounded and frightening charges.

Although the exaggerated charges have been exposed by competent authorities — and refutations published in established journals — these refutations in many cases have not even been mentioned by the mass media which presented the original scare stories.

As a result of the anti-DDT hysteria, we are now at the point where politicians may ban the most beneficial chemical known to man because a big publicity campaign has succeeded in giving DDT an image completely false.

If the political community allows itself to be pressured into over-riding the prestigious and highly qualified scientific-technical committees which have thoughtfully studied all of the benefits and risks of DDT, it will open a door it will never be able to close.

Nature is deaf to political decisions. She can only be used to work for man if her immutable laws are respected. Honest scientists will not work in an environment where their work is not respected.

If DDT is banned, this will be a direct affront to much of the U.S. scientific community.

The fundamental facts about DDT are:

• There are now living in a state of health something like ONE BILLION human beings who would be dead or ill had it not been for DDT; it has protected them during the past 25 years from malaria, plague, typhus, yellow fever, diarrhea, sleeping sickness and several other insect-borne diseases which sapped the vitality of, and killed millions of people prior to the discovery of DDT.

• In the manufacture and field application of DDT during these 25 years NOT ONE SINGLE HUMAN BEING, of the thousands exposed, has been killed by the accidental ingestion of DDT. As of now, there is no evidence DDT is harmful to humans, many of whom have been over exposed to it for as long as 25 years.

(OVER)

THIS IS A REPRINT

● These facts can be readily verified by the World Health Organization and the U.S. Public Health Service, who of course have no financial interest in the sale of DDT. It is absurd to call DDT a "poison." There is NOT ONE OTHER known drug or chemical with such a remarkable human safety record.

Having set down the basic facts about DDT and human health, which is my own field, I want to comment on the threat, if any, that DDT presents to lower animals.

There is no evidence that most birds, fish or animals have been harmed by DDT. Birds such as robins, blackbirds, swallows, mourning doves, and starlings, etc., have—according to the Audubon Society's own counts—increased substantially and steadily since DDT was first used in the United States.

All of the major kinds of wild animals—deer, antelope, bear, elk, mountain sheep, and so on—that are systematically counted by the U.S. Department of Interior have also shown substantial increases since DDT began to be used in the United States and Canada.

Predator birds such as the brown pelican, peregrine falcon and bald eagle are supposed to be laying thin-shelled eggs because of DDT. On page 437 of the 677 page Mrak Commission Report (Dr. Emil N. Mark, Chancellor Emeritus, U.C. Davis) it says:

"There have been reports of a number of wild bird species, notably the peregrine falcon and the bald eagle, which are showing declining reproductive success and population numbers. This decline has been attributed to chlorinated hydrocarbon pesticides by some observers (Risebrough, 1969; Wurs-

ter, 1969). The estrogenic and enzyme effects noted above indicate a possible mechanism for such an etiology. However, there seems at this time to be a very reasonable doubt that residues of the chlorinated hydrocarbon pesticides are found in the natural feed of these birds at levels equivalent to the dosage necessary to produce these effects."

There is absolutely nothing but speculation to link DDT with the declines that have been observed in crab, lobster or fish catches here and there.

The alleged claim that DDT dissolved in the oceans can inhibit photosynthesis in algae and thus threaten our oxygen supply is demonstrably false. This is because DDT cannot, under natural conditions, be dissolved in sea-water in a concentration greater than 1.2 parts per billion parts of water. At that concentration, algae show no adverse effects.

In the experiment on which this frightening claim is based, it required a concentration above 10 parts per billion of water to affect the algae. But (and this is the key point), these higher concentrations could be produced only by first dissolving the DDT in alcohol.

Thus, we see that this aspect of the anti-DDT propaganda collapses and is basically a scientific shell-game. So what about the claims that DDT persists for years and can build up to levels which will eventually become dangerous?

First, recall that DDT has never in its widespread use permanently damaged a single human being.

Persistent

The most important characteristic of DDT is precisely its persistence. Because of this characteristic it need only be applied at relatively infrequent intervals.

For example, it can be sprayed on the ceiling of a hut or barn—where mosquitos rest—and for many weeks it will kill all mosquitos which land there. Less persistent insecticides would have to be sprayed many times to achieve a similar result.

It should also be pointed out that DDT which is sprayed on the ceiling of a hut or barn to kill mosquitos and flies does NOT "contaminate" soil or water. But it does eventually decompose in the air. That's why huts and barns need to be re-sprayed every few weeks.

The truth about the persistence of DDT is that it varies under different conditions of heat, of moisture and of oxygen exposure. In some situations it degrades quite rapidly, and in other situations more slowly. Where its use has been declining for some time, as in the United States, its concentration in soils and water is falling. And there is absolutely no reason to consider it as any kind of threat to the public health in California.

If the production of DDT is stopped, these are some of the results that will follow:

- There will be great increases in the amount of disease and deaths in the undeveloped world.
- The cost of many foods and fibers in the U.S. and elsewhere will rise sharply because DDT is one of the major reasons for the increased yields of modern farming methods.
- Politicians will ultimately find themselves making other scientific decisions that they are not qualified to make.

Los Angeles Times

HARRISON GRAY OTIS, 1881-1917
HARRY CHANDLER, 1917-1944

NORMAN CHANDLER, 1944-1960

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Milk and other foods contain cholesterol, carcinogenic to experimental animals, when administered in sufficiently high quantities. Arsenic is present in cows' milk at levels of about 0.3 to 0.5 ppm on a dry-weight basis and occurs naturally in many foods.

Pesticides are not tolerated by state and federal agencies at concentrations greater than 1% of the maximum levels found to be safe in extensive experiments with rats and other laboratory animals. If the same criterion were used for naturally occurring substances some common vegetables grown "organically" as well as vitamins A and D in egg yolk and butter, D in milk and zinc and arsenic in seafood would be ruled out as foods.

The decline of the brown pelican on Anacapa Island, blamed on DDT, happened not when DDT usage was at its peak, but after the greatest oil spill in Southern California history. Mercury, lead, arsenic and polychlorodiphenyls in ocean water, and the incursions of ecologists in helicopters into breeding areas, are not mentioned as factors deleterious to pelicans in the current emotional campaign against DDT.

In California the precipitous and ill-advised substitution of the much more poisonous organophosphorus insecticides for DDT, for the protection of certain agricultural crops, has resulted in the death of personnel applying them, more treatments per year at much greater expense to the farmer, and less effectiveness against pests and the slaughter of millions of bees.

I would be the first to admit that mankind is faced with some difficult problems, all deriving in some way from unbridled population explosion. To feed and clothe a rapidly increasing population, an increasingly more efficient agricultural production is required—greater production on continuously shrinking acreage of arable land. Pesticides used under adequate controls and supervision will continue to play an important role. Pollution problems from this gigantic enterprise have been relatively trivial compared with the problems related to pollution of the air and water, sewage disposal, solid waste disposal, noise, etc., that result from urbanization and industrialization.

WALTER EBELING
Professor of Entomology
UCLA

'DDT Is One of Mankind's Major Triumphs'

Like the majority of my colleagues engaged in entomological research, I have devoted much time to attempts to develop safer insecticides or pest control measures not requiring the use of toxic chemicals. I am as concerned as anyone with the quality of our environment. However, I believe it is also important to bring to the attention of your readers a side of the DDT controversy to which most of them have probably never been exposed.

DDT is one of mankind's major triumphs. Probably no other compound, not even penicillin, has saved as many lives. It has been the principal insecticide in the control of insect vectors of malaria, yellow fever, typhus, elephantiasis, bubonic plague, cholera, dengue, sleeping sickness and dysentery. In mosquito control it has been applied principally to the inside surfaces of homes and other buildings, with little or no opportunity for environmental contamination.

In Ceylon where the age-old scourge of malaria was virtually eradicated by DDT, the spray program was abandoned for political, emotional and unsound reasons. Within a few years the incidence of malaria increased to about 1 million in a population of 11 million. Orders were then placed in the United States for rush deliveries of DDT which totaled nearly 10 million pounds within one year. DDT was banned in Sweden, Norway, Finland, Ontario, Canada, and Maine, but all had to rescind their ban as soon as the disastrous consequences in field and forest became evident.

Among the hundreds of thousands of persons applying DDT throughout the world and among

the hundreds of millions whose homes have been treated, no harm has been observed from its use except for a few isolated cases of accidental consumption of a large quantity or attempts at suicide. The amount of DDT required to produce adverse effects can be judged by the fact that single doses of 5-gram quantities (over two teaspoon full) and higher have been administered to man in the successful treatment of barbiturate poisoning. This is about four times the quantity taken in by the average person in a 70-year lifetime. All patients rapidly recovered from the barbiturate poisoning and without noticeable side-effects.

Propaganda implying a casual relationship of DDT to cancer was based on an investigation in which doses of DDT 3,000 to 160,000 times the dose (per unit of body weight) found in the average person were found to produce nonmalignant tumors in the livers of rodents (and no other order of animals). The tumors disappeared when the dosage was reduced to only 1,000 times the average human intake. The words "cancer" or "cancerous" were never used by the investigators.

When DDT usage was at its height in the United States, the average concentration of DDT in mothers' milk was 0.13 ppm, but, along with the continuous decline in DDT usage in this country, the concentration in mothers' milk has likewise declined to 0.03 and 0.04 ppm. A mother's milk contains nicotine, 500 times more poisonous than DDT, if she has been smoking.

CURRICULUM VITAE

Joseph W. Still, M.D., M.P.H.
1408 Edgecliff Lane
Pasadena, Calif. 91107

OUTLINE OF PROFESSIONAL EXPERIENCE

Mass Preventive Medicine

*In One of first 5006
- Reported cooperative
Health Plans in
the U.S.*

- 1939-41 General Practice, Greenbelt, Md.
- 1941-1946 U.S. Army Medical Corps - 1st Lieutenant → Lt. Colonel
- 1941-43 Post Epidemiologist and Chief of Dispensaries, Ft. Belvoir, Va.
- 1943-1945 Asst. Chief of Preventive Medicine MTO/USA Algiers and Caserta, Italy
- 1946 Chief of Medical Records and Statistics, Veterans Administration, Washington, D.C.
- 1947-49 District Health Officer for State of Virginia - Located in Fauquier and Winchester, Virginia

*Research on
The Course of
Aging*

- 1949-51 Instructor, Department of Physiology, George Washington University School of Medicine, Washington, D.C.
- 1951-58 Asst. Prof. at same institution

*Mass Pract.
Medicine*

- 1958-60 Director, Bucks County Health Department, Doylestown, Penna.
- 1960 Self-employed, Doylestown, Penna.
- 1961-62 Director, Dept. of Health, Recreation and Welfare, Camden, New Jersey

1/2 yrs. EXPERIENCE WITH ADDICTS & CRIMINALS

- 1963 Chief of Research, California Rehabilitation Center, Corona, California

1964 to date Private Practice of Personal Preventive Medicine,
El Monte, West Covina and Arcadia, California

12 YEARS IN

EDUCATION

Dr. Still is an M.D. whose medical specialty is Preventive Medicine. Since World War II he has devoted much of his professional life to research and education in the general field of psychophysiology and into the cause of and delay of aging. He is a physician-scientist whose wide professional interests and experiences have resulted in published research in the fields of biochemistry, physiology, psychology, epidemiology, public health and personal preventive medicine.

His M.D. degree is from Nebraska and his M.P.H., preventive medicine degree, is from Johns Hopkins. He has also done postgraduate study at George Washington Medical School and the Washington School of Psychiatry.

PROFESSIONAL EXPERIENCE

After completion of his internship and a brief experience in private practice, Dr. Still joined the U.S. Army Medical Corps in June 1941 and served until November 1946. He became a Lieutenant Colonel and served for over two years as Assistant Chief of Preventive Medicine in the Mediterranean Theater of Operations. He assisted in the planning and operations for some of the first uses of DDT to combat a typhus epidemic in Naples, malaria, diarrhea, dysentery and sandfly fever in all areas where our troops were located and a pneumonic plague outbreak in Oran. He was awarded the Bronze Star for his work in the MTO. Before coming to California he was the Director of Health, Recreation and Welfare in Camden, New Jersey.

After the war he spent a number of years in the physiology department of George Washington University Medical School where he taught physiology and conducted physiological research on problems of kidney function, blood viscosity and in theoretical, physiological and biochemical research on the chemistry of aging.

His best known scientific works were the development of a "Cybernetic Theory of Aging," the development of a permanent (blood vessel) intubation technique in rats and the invention of the Automatic Blood Collecting (ABC) Instrument on which he holds a basic patent. His most recent scientific contribution (1967) has been the demonstration that there are five levels of life which may be clearly distinguished from each other, hence five different kinds of death which occur in human beings. This observation has important implications for the moral and legal questions of abortion, birth control, euthanasia and organ transplants.

Since leaving George Washington University Medical School in 1958 he has been involved in the practice of preventive medicine. Approximately five years were spent in public health work in Bucks County, Pennsylvania and Camden, New Jersey. He came to California in 1962 to be Chief of Research in the California (Narcotics) Rehabilitation Center but resigned after about a year in the department to enter the private practice of medicine. This practice he calls Personal Preventive Medicine. It is concerned with the prevention of premature aging in individuals who suffer from such pre-disease conditions as obesity, hypertension, hypoglycemia and arteriosclerosis, as well as from a variety of symptoms and conditions resulting from the mild to moderate degrees of endocrine deficiencies which are characteristic of advancing age.

PUBLICATIONS

He has published scientific papers in all of the major areas of medical science -- biochemistry, physiology, psychology, and health sociology. He also has written for such popular magazines as New York Times Sunday Magazine, Better Homes and Gardens, Bulletin of Atomic Scientists, Clubwoman, and others.

He has published two books, Science and Education at the Crossroads, Public Affairs Press (1958), and Peace by Finesse (1963). Another book, God Without Magic: The Levels of Life and Love, is in manuscript but unpublished. He is presently working on two books - one concerned with helping obese people achieve permanent slenderness and the other relating to the use of Personal Preventive Medicine to decrease the likelihood of premature disability and death from one or other of the degenerative diseases associated with aging.

SOCIETIES AND HONORS

American Public Health Association
 American Board of Preventive Medicine and Public Health (Diplomate)
 American Physiological Society
 Washington Philosophical Society
 American Academy of Political and Social Science
 Washington Academy of Sciences
 New York Academy of Science
 1960 Strategy for Peace Conference
 Royal Society of Health
 Pan-American Medical Association
 American Geriatrics Society
 American Society of Clinical Hypnosis
 Former Member of Advisory Council of National Recreation Association
 Bronze Star for Work in Surgeon's Office, Mediterranean Theater, during World War II
 Sigma Xi
 1965 White House Conference on I.C.Y.
 1966 Gordon Research Conference on the Biochemistry of Aging
 Participant in many conferences and symposia dealing with scientific and medical problems

Listed in: Who's Who in the West
 American Men of Science
 Leaders of American Science
 Dictionary of International Biography

Experiences, Inventions and Novel Techniques, as well as other firsts by Joseph W. Still:

1. 1939-1941 -- Member of first group of physicians serving one of the first prepaid, cooperative health associations established in the United States, the Greenbelt (Maryland) Health Association. The town of Greenbelt, Md., was a unique community. It was one of the three planned communities built in the New Deal days as a demonstration-experiment in community planning. It was also unique in that all of its internal business was conducted on a cooperative basis. This experiment was conducted under the auspices of the Commonwealth Foundation with the approval of the Federal Government.

2. 1941-1943 -- While serving at Fort Belvoir, the first epidemic of hepatitis to hit the U.S. Army during World War II broke out. As the Post Epidemiologist he undertook an epidemiological study which eventually embraced over 600 cases of jaundice and/or hepatitis. This was one of the first studies to conclusively prove that the hepatitis outbreak was due to a virus which was transmitted in the Yellow Fever vaccine given the soldiers. The study was transmitted to General Stanhope Bayne-Jones (then in the Army Surgeon General's Office) but was classified and not released for publication.

3. 1941-1943 -- As Chief of Dispensaries, Fort Belvoir, he developed and operated in association with the Chief of the Training Division of the Engineers Training Center a "screening" arrangement to screen out all of the hundreds of individuals with physical defects who were reaching the E.T.C. in the early months of mobilization for World War II. Theoretically, only men without serious defects were to be sent to the E.T.C. but the home-town physical examinations failed to screen out hundreds of men with serious defects. And with several thousand new men coming to E.T.C. each week for an 8-10 week basic training period, it was necessary to build a large-scale medical-administrative machine to screen out those with defects and to insure that these defects were either corrected or the soldier classified for limited duty or discharged. Another responsibility at Fort Belvoir was that of venereal disease control officer.

4. 1943-1945 -- As Assistant Chief of Preventive Medicine (Chief Surgeon's Office, Mediterranean Theater of Operations), he was associated with the following firsts:

- a. Organization of Medical Machine Records System. The Army's reporting system (Form 86AB) then in use was not adequate for preventive purposes and other planning. He carried the major responsibility for planning, installing and operating a new system which provided the information necessary for an effective preventive medicine program. This system served as a guide in reforming the entire communicable disease reporting system of the Medical Department. A subsidiary aspect of this job was the development of a book of statistical charts for the Theater Surgeon which gave him in graphic form all routine statistical information he needed.
- b. Represented the Surgeon's Office in the Theater Committee which organized the first safety program in an overseas theater. This program prevented a monthly average of 50 deaths and 2500 hospitalized cases during each of the last twelve months of the war.
- c. Initiated a Gallup-type study of the sexual behavior of soldiers in that Theater which served as a guide in planning venereal disease policies in that Theater, and also played a major role in changing the basic policy of S.G.O. toward V.D. after the war. This was a pre-Kinsey report on sex activity of American males.
- d. Compiled the initial drafts of the History of Preventive Medicine for the Mediterranean Theater of Operations, in two versions, written and pictorial.
- e. D.D.T. was first used in M.T.O. to stop the Naples typhus epidemic to control malaria on the Army's beachhead and elsewhere in Italy and Sicily, to control fly-borne diseases and to stop a sharp outbreak of pneumonic plague in Oran. He was associated with all these developments. As a result he was among the first to know that a "population explosion" would result from this powerful tool of mass preventive medicine. Because of this realization he has made the search for how to organize a permanent world peace his major avocation.
- f. Veterans Administration, Central Office (Washington, D.C.) -- As Chief of Medical Records and Statistics Office, organized the first Medical Records and Statistics Office for the Medical Department. Previously, this function

had been a subsidiary part of the duties of the Budget and Finance Division of V. A. This organization job entailed the hiring of about twenty statisticians, medical records analysis and machine records specialists in the upper civil service grades, and uniting this top staff with about 200 clerks, machine operators and others to form the R&S Office of the Medical Department.

5. 1947-1949 -- Health Officer for three Virginia counties. He developed and operated in cooperation with the County Medical Society a medical-administrative screen to detect all the children with physical defects in the 1st, 4th and 7th grades of the Prince William County, Virginia, schools. After detection a vigorous follow-up program was carried out which corrected many of these defects. Surprisingly, it was found that more than a few parents were opposed to the use of modern surgery or other corrective procedures, so it was impossible to obtain 100% correction.

6a. 1949-1958 -- While doing research in the physiology department of George Washington Medical College, he invented and perfected the technique of permanently implanting a polyethylene plastic tube in the aorta of rats. With this technique it became possible for the first time to inject a marking substance (India ink or tagged plasma or radioactive red cells) into the aortic bloodstream of unanesthetized and normally positioned rats. Thus it became possible to study under physiologically normal conditions the effects of various agents on the fine circulation of different organs such as the kidney. This preparation also permitted, for the first time, the recording of direct aortic blood pressure in small unrestrained and unanesthetized animals such as rats.

The intubated rat permitted study of the effect of pain (and other agents) on blood and plasma viscosity. As a result, it was discovered that both of these blood factors are subject to rapid change in response to a number of stimuli.

The permanent intubation technique is now widely used in experimental situations. For example, Dr. C. P. Lyman of Harvard has said it has revolutionized hibernation research.

6b. 1956 -- Conceived and published the Cybernetic Theory of Aging -- one of the few chemically testable theories of aging. The other is the cross-linkage theory of Bjorksten which can be harmonized with and is complementary with the Cybernetic Theory. He considers the practice of Personal Preventive Medicine to be a practical application of the theory. The primary tool of this kind of medicine -- preventive endocrinology -- involves correcting and thus combatting the endocrine deficiencies which occur with advancing aging. Since the endocrine glands are a part of the Cybernetic (nervous-endocrine) system which controls all chemical and physiological activities in our bodies, it follows that Personal Preventive Medicine presents a scientifically rational approach to the delay of aging. Indeed the reversal of degenerative changes has been objectively demonstrated in many patients who have now been receiving this kind of care for several years.

6c. 1957-1958 -- Developed a new technique for carrying out chemical "turnover" studies in order to challenge the Cybernetic Theory of Aging. Using this new technique for radioactively tagging the proteins of embryo and young rats up to the time of weaning, he succeeded in demonstrating that some chemical parts of the nerve and muscle cells are highly stable -- probably completely so. This finding, along with a similar experiment reported about the same time by Thompson and Ballou, upset the until then universally held belief that "all chemicals are turning over all the time." The demonstration of this chemical

stability also provided strong support for the Cybernetic Theory of Aging.

6d. His 1957 New York Times Magazine article, "Man's Potential and His Performance", has been credited by educators as making a substantial contribution to educational theory.

6e. Invented the Automatic-Blood-Collecting Instrument -- U.S. Patent #3, 043, 303. This instrument is intended to facilitate the carrying out of many kinds of dynamic physiological experiments under much more normal circumstances than has ever before been possible. It will also make possible the collection of blood samples from an animal orbiting in space or from a freely roving animal.

6f. 1958 -- Credited with the decisive medical opinion in the appeal (to the U.S. Department of Labor, Employees' Compensation Appeals Board) of Blackburn vs. the U.S. Department of Agriculture. This is considered a leading law case because Blackburn's widow was awarded compensation for his death from coronary thrombosis on the grounds that it resulted from prolonged chronic stress (excessive overwork and resulting fatigue).

6g. 1958-1959 -- Several articles written for popular audiences about economic, medical, psychosocial and political aspects of aging have proved prophetic because the relatively obscure problems they dealt with then have become matters of general interest in the 1970's. These were as follows:

- (1) Medical, Social and Economic Aspects of Preventive Geriatrics - may have been the first article published in the United States which drew attention to the major implications of the increased longevity of Americans which has resulted from the almost complete control of contagious and infectious diseases that now is possible. This paper especially pointed to the need to develop personal preventive medicine to help people delay the onset of degenerative diseases and aging itself.
- (2) Why Can't We Live Forever?, published in Better Homes and Gardens, discussed in popular language the three leading aging theories and ended with this statement: "Medical experience has taught us that when we fully understand a chemical event, we are (usually) able to manipulate and alter or modify it. . . . Already aging may have been brought into the realm of chemical research (the passage of time has confirmed that this is a fact). . . . Aging may prove to be no more fatal or inevitable than smallpox, polio, pneumonia or tuberculosis." This statement has not only proven to be prophetic; it also has encouraged others to take a hopeful and enthusiastic approach to aging research.
- (3) Can We Afford An Aging Population?, published in The Clubwoman, pointed out that the over-65 population was growing at a more rapid rate than any other segment of our population. It predicted that the economic load of supporting such a large population, most of them in forced idleness, would eventually place an insupportable burden on the working population. It therefore recommended removal of the Social Security limitation on earnings from age sixty-five to seventy-two and it urged Congress to also enact laws to strengthen and protect the laws controlling pensions, to the end that most working people would receive decent pensions as well as their Social Security payments to enable them to take

things a little easier and enjoy their so-called golden years.

- (4) Boredom: The Psycho-Social Disease of Aging, pointed to the damaging affects - physical and mental - of the boredom which too often is the result of forced retirement.
- (5) Boredom and Idleness - drew attention to the harmful aspects of these conditions for youth as well as for senior citizens. It also pointed out that the natural bonds between grandparents and grandchildren and between older and younger people are being broken by our social security policies. This has adverse influences in many areas of our economic and social life.
- (6) How Much Can We Make of Our Lives, Senior Citizen, August 1958.
- (7) Old Dogs, New Tricks, New Lives, 65 Magazine, 1959.
- (8) An Attempt to Show the Links Which Connect the Social-Psychological and Physiological Events Which Result in Coronary (and other) Thromboses, with some suggestions for Breaking the Connections. Chapter in Exercise and Fitness, U. of Illinois Press, 1960.

6h. Published the first post-Sputnik book-length critique of U.S. science and education. This book, Science and Education at the Crossroads, was the first of that vintage to:

- (1) Recommend the formation of a National Education (Board) Council to operate on a nondirective basis by establishing educational standards. This would be done simply by preparing and publishing descriptions of the "ideal" curricula our schools should be teaching, and by conducting annual exams for those who wished to take them.
- (2) Attack the validity of the I.Q. test as a means of identifying creative and inventive children.
- (3) Recommend the establishment of a nationwide system of nursery schools and kindergartens as a way of overcoming the cultural deprivation of millions of Americans growing up in slums and backward rural areas -- what is now called Operation Head Start.
- (4) Recommend the establishment of a democratically controlled national personnel system to make more effective use of our scientific-technical personnel.
- (5) Outline an approach to the development of a "Scientific Nervous System".
- (6) Recommend that we increase the percentage of grant support to individuals and agencies and decrease greatly the percent of project support -- the latter being held to be costly, illogical and open to many abuses.
- (7) Demonstrate the mutuality of interest between the U.S. and the U.S.S.R. in helping the underdeveloped world overcome its economically backward status as quickly as possible. In a related article in the Bulletin of Atomic Scientists

it was pointed out that the U.S., which played the major role (through the introduction of DDT, antibiotics and vaccines) in causing the "population explosion" in the underdeveloped world, was doing relatively very little to help those nations develop economies capable of providing a decent life -- even bare necessities. Thus many of the hundreds of millions who owed their lives to these U.S.-introduced medical "miracles" hated the United States because they were alive but hungry.

7a. 1959-1960 -- Director of Health Department, Bucks County, Pennsylvania.

7b. 1960 -- Published The Long Road to Peace, which further elaborated the mutuality of interest of the Great Powers in helping the small weak nations overcome their economically backward status. Essentially the same thesis by a Soviet scientist, Andrei Sakharov, was widely applauded when it was published in the United States in 1968.

7c. Let's Use Common Sense About the Aged, Medical Economics, April 11, 1960.

8. 1961-1962 -- Director of Health, Welfare and Recreation in Camden, New Jersey.

9a. 1962-1963 -- Chief of Research, California (Narcotics) Rehabilitation Center.

9b. Wrote two unpublished books, God Without Magic and Sick People, Sick Families, Sick World.

9c. 1963 -- Published Peace by Finesse, a "positive" proposal for making peace in at least a part of the world by having the nations of the underdeveloped world promulgate a treaty in the General Assembly which would:

- (1) Permit the signatories to the treaty to unite in a Zone(s) of Peace from which the Cold War would be excluded.
- (2) Permit the member nations in the Zone(s) of Peace to establish machinery for policing their own borders, thus making these zones independent of the Security Council and thus of the Great Power struggle.
- (3) Permit the Zone(s) -- there probably would be several regional zones established -- of Peace to establish improved machinery for planning and carrying out their own economic advancement.

10a. 1963 to date -- Private practice of Personal Preventive Medicine.

10b. 1965 -- Because of the growing worldwide interest in Peace by Finesse, an updated second edition was published, and in 1967 a third edition was published.

11a. 1966 -- Published "Needed: A Total National Scientific Research & Development Budget" which drew attention to the fact that while the United States was allocating \$5000 million a year for space exploration, we were failing to allocate enough money for the kidney machines needed to save the approximately 35,000 people who were dying each year for lack of these machines. Soon thereafter Congress began to provide larger sums of money for this purpose and we no longer hear of any shortage of machines or centers to help these unfortunate people.

11b. 1966 -- Sent the basic idea of The Levels of Life to Pope Paul VI for consideration in regard to the problems of abortion, birth control and euthanasia, which were then under review, and entered the competition for the estate of James Kidd. The Levels of Life was the only presentation to the court which was actually rooted in the physical sciences (embryology, neurology and evolutionary theory). Nevertheless the judge eventually gave the money to the American Society for Psychic Research, which offered no proof of any kind but merely asked for the money to do further research.

12. 1968-1971 -- Published the Levels of Life idea or short articles referring to it in nine different journals or books, as follows:

- (1) "When Does a Human Life Begin?" Amer. Jour. Public Health, Vol. 58, No. 4, April 1968.
- (2) "The Three Levels of Human Life and Death, the Presumed Location of the Soul, and Some of the Implications for the Social Problems of Abortion, Birth Control and Euthanasia," Med. Annals of Dist. of Columbia, Vol. 37, No. 6 (June 1968).
- (3) "Objective Diagnosis of Human Death" Jour. Washington Academy of Sciences, Vol. 59, pp 46-49 (1969).
- (4) "To Be Or Not To Be - Alive Or Dead?" Jour. Amer. Geriatrics Soc., Vol. 17, No. 5 (1969).
- (5) "When Does Human Death Occur?" Trial & Tort Trends, 1969 Belli Seminar.
- (6) "Legal Levels of Life and Death," J. Amer. Institute of Hypnosis (Jan. 1970).
- (7) "Three Levels of Life and Death," Cryonics Reports 4:8 (1969).
- (8) "We Need to Know Not Only When Human Life Ends But Even More Important, When It Begins," Arch. of Foundation of Thanatology, Summer 1970.
- (9) "The (Five) Levels of Life and Semantic Confusion," ETC: A Review of General Semantics, 28:9 (1971).

13. 1969 -- Published:

- (1) Needed: A Global Scientific Nervous System - Summary in Activitas Nervosa Superior, State Health Publishing House, Malostranske Nam 28, Prague 1, Czechoslovakia (Dec. 1969). Full text in The Relevant Scientist, Nov. 1971 1:19.
- (2) The Cybernetic Theory of Aging, Summary in Geriatrics Digest, 6:22 (Dec. 1969) and in Activitas Nervosa Superior, State Health Publishing House, Malostranske Nam 28, Prague 1, Czechoslovakia (Dec. 1969). Full text in Jour. of Amer. Geriatrics Society, Vol. 17 page 625 (1969).
- (3) Adult Preventive Medicine, the Fourth Phase in the Evolution of Medicine. Jour. Amer. Geriatrics Society, Vol. 16, No. 4 (1968).

- (4) Property Tax for Schools Unfair, Los Angeles Times Editorial Section, June 4, 1969.
 - (5) Noninterference Must Come First, Bulletin of the Atomic Scientists, Vol. 24, October 1968.
 - (6) Longevity: Another View, Medical Tribune, Nov. 7, 1968.
14. 1971 -- Published: Needed, a Global Scientific Nervous System. The Relevant Scientist, Vol. 1 page 19 (1971).
 15. 1972 -- Published:
 - (1) The Changed Meaning of Freedom of the Press and The Misuse of Our Social Nervous System. The Relevant Scientist, Vol. 2, page 5 (1972).
 - (2) Hypothyroidism: Prevalent in Obesity, J. of Obesity and Bariatric Medicine, Vol. 1, page 35 (1972).
 16. 1973 -- Working on the draft of a book on obesity tentatively titled "When All Diets Fail", and making plans to institutionalize personal preventive medicine in a Health Maintenance Center to serve as a model that will lead to widespread replication of the model and the establishment of personal preventive medicine as the "fourth phase in the evolution of medicine."

Personal Preventive Medical Group, Inc.

Joseph W. Still, M.D. M. P. H.
President and Director

TO BE OVERWEIGHT IS TO AGE PREMATURELY:

THAT'S NOT NECESSARY

If you are seriously overweight or if you've had a weight problem for some time, you are aging prematurely.

Since the major causes of overweight - endocrine deficiencies and imbalances and nutritional errors - can be overcome and controlled, it follows that doing this will actually delay and even turn back the degenerative changes that occur with increasing age.

The histories, pictures and charts which follow demonstrate the truth of the above statements.

Phone (213) 339-1224
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OVERWEIGHT AND PREMATURE AGING

Introduction

A patient recently asked me, "Why is your practice called personal preventive medicine?" This paper is an answer to her and to others who may also think I am only interested in reducing fat people. I answered that my medical specialty is preventive medicine and my entire professional life has been spent in one or other aspect of prevention. This includes nine years of research on the cause of aging and in teaching endocrinology at George Washington University. During those years I developed the widely accepted Cybernetic* Theory of Aging. In those years I also looked into the causes of the degenerative diseases - arteriosclerosis, cancer, hypertension, diabetes, etc. These studies led to the realization that although we don't fully understand the nature of these diseases, it is nevertheless possible to do a great deal to delay their onset. These experiences are mentioned as prelude to explaining that the Cybernetic Theory postulates that the key system which breaks down as we age is the nervous-endocrine system, the system which controls all of our biochemical and physiological activity.

Now it happens that the two most frequent causes of overweight - hypothyroidism and hypoglycemia - are due to defects in the endocrine system. Hypothyroidism if untreated leads to premature arteriosclerosis and eventually to coronaries, strokes and high blood pressure. Hypoglycemia if untreated leads to diabetes which in turn causes hardening of the arteries, high blood pressure, coronaries, strokes, blindness, etc. Estrogen deficiency, which occurs to women as their ovaries cease functioning, leads to osteoporosis (porous bones) and also hastens the progress of arteriosclerosis. And other endocrine abnormalities lead to diabetes, Addison's disease, arthritis and many other less common degenerative diseases which will not be discussed here.

The Results of Thyroid and Estrogen Replacement

The before and after treatment pictures and records on the next pages give what seems to me clear proof that the aging process in these two women not only was stopped but even reversed by endocrine therapy.

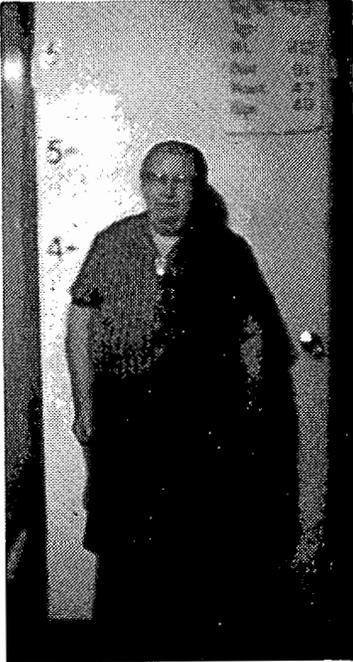
Both of these women were hypothyroid and their eating habits were satisfactory. Of course, because of their ages both of them also needed to take estrogen to protect their bones and arteries. Patient No. 1, who was already seventy-nine, had not done this. Consequently she had lost four inches in height before I first saw her.

* Cybernetics refers to the mechanisms that control complex systems. And the human body, with its 30 to 100 trillion cells, is the most complex system we know about. The Cybernetic Theory may eventually assist researchers in discovering the fundamental cause of aging. But its greatest merit is that it has practical value now, in that it explains the youthening (anti-aging) effects of thyroid, estrogen and other hormones which may become deficient at any age, but increasingly so with advancing age.

PATIENT No. 1

Age: 79, Height: 5', Weight: 212#
Blood pressure: 210/120
Physical state: Unable to walk two blocks. Careless of personal hygiene.
Mental state: What little talking she did was, according to her daughter, regarding death—her own or someone's else.
Diagnosis: Hypothyroid
Treatment: Thyroid & Estrogen. No appetite depressants.

Age: 83, Weight: 127 to 132#
Blood pressure: 120 to 140/80
Physical state: "Up and stirring around her house or neighborhood all day." Has felt better during past 3 years than any other time during past 15 years.
Mental state: She is now alert & full of zest for life as any healthy 80 year old can be.



PATIENT No. 2

Age: 62, Height: 5', Weight: 151#
Blood pressure: 140/90
Physical state: Overweight since teens despite reducing many times. Patient was at least 25% overweight. Feels sluggish all the time.
Mental state: Has noticed loss of memory and alertness.
Treatment: Thyroid & Estrogen.
Diagnosis: Hypothyroid

Age: 65, Weight: 107 to 109 pounds for the past 15 months.
Blood pressure: 120/80
Physical state: Never has been at this weight since she has had her full height. Grey hair has now turned dark & she is very energetic.
Mental state: Memory & alertness & general feeling of well being have all returned to earlier status.



The results of taking thyroid and estrogen are shown on the previous page. I believe you'll agree that if by merely taking thyroid and estrogen hormones this patient could in a few months lose 80 pounds, have her blood pressure reduced from 210/120 to 130/80, have her mental and physical vigor and bowel and bladder control restored to that of a healthy 80-year-old and be maintained that way for ^{Now five +} ~~three~~ more years and still be in a state of good health with a life expectancy at least five to ten more years; that if all that can be done by the practice of personal preventive medicine, this is proof that it is already possible to reverse and substantially delay the advance of the aging process. *

If you agree, does it not also follow that the 40, 50, 60 or 70-year-old person who is not yet senile but who is seriously overweight, and/or whose blood pressure is above normal or who is hypoglycemic or diabetic, is aging prematurely? If your answer to that question is also yes, and if you have any of the symptoms or conditions that the above patients had, ask yourself how many extra years it may be worth to you to be restored to health and stay that way permanently. *

Patient No. 2 was 62 years old when first seen in my office. She had been overweight since her teens. She had reduced many times but always put the weight back on. Unfortunately no doctor had ever told her why she had a weight problem. In fact she was hypothyroid and all that she had to do to become slim for the first time in her life and stay that way, and remain healthy and really alive in the future, was to take thyroid and estrogen in the right dosage for her. Patient No. 2 not only looks younger and enjoys wearing pretty clothes only a slender woman can wear, but she again feels happy and energetic and has real zest for living. Though the degenerative changes in Patient No. 2 were much less advanced than in Patient No. 1, they were definitely present - excessive fatigue, loss of memory, loss of hair and rapid greying. All of these symptoms disappeared with endocrine treatment.

Compulsive Overeaters Are Usually Hypoglycemics

Many seriously overweight people have been called "compulsive overeaters", "neurotics" or "glucoholics" because they eat large amounts of sweets and/or starches. Most such people are hypoglycemics and many are also hypothyroid. Most of them have been made to feel guilty and even sinful about their weight. Because hypoglycemia often leads to diabetes, it is very important to control hypoglycemia before diabetes results. The histories and results of treating two hypoglycemics follow. Neither was given appetite depressants.

Patient No. 3, who was hypoglycemic and hypothyroid, was twenty-four when I first saw her. She complained of excessive fatigue, frequent headaches and long-standing acne as well as her excess weight, 216 pounds. Because she is 5'4-1/2" tall, she should weigh about 125 to 130 pounds. She has been heavy since age thirteen when her menses began. Her way of eating was typical of a hypoglycemic. She wasn't hungry in the morning, so she seldom ate until noon. She ate nothing in the afternoon but had an early starchy dinner at 5:30 P.M. and then usually ate lots of cookies and other sweets in the evening. She ate very little fruit or salad.

Aside from her overweight, the only physical finding of note was excessively dry elbows and facial acne. These skin conditions are often due to hypothyroidism. The one hour post-prandial (after Glucola) glucose test was elevated (180 mgm%) and her thyroid (PBI) test was near the lower limit of (Starr's) normal 5.7 mcg%. She was given thyroid and

* I feel sure that these facts indicate that life expectancy could be increased by at least 5 years if all people who are suffering from these controllable conditions were being similarly treated. And the quite simple use of Nursing Home would be greatly reduced.

told to follow the hypoglycemic eating pattern - three balanced meals about five hours apart plus protein snacks mid-morning, mid-afternoon and evening. As can be seen from the record below, she has lost weight beautifully except for the few weeks when she stopped taking thyroid. Because she continued to eat properly during that period without thyroid, she gained only a half pound.

<u>Date</u>	<u>Weight</u>	<u>Pulse</u>	<u>Blood Pressure</u>	<u>Bust</u>	<u>Waist</u>	<u>Hips</u>
1/5/74	216	96	150/80	47	40	49
2/2/74	203	88	120/70	44	36	46
3/2/74	186	80	120/70	43	32	44
3/30/74	178	72	110/70	42	31-1/2	42
4/20/74	172	72	110/70	42	31	40
6/1/74	166	80	120/70	40-1/2	31	41
7/13/74	162	88	120/80	39	30	41
- Off treatment nine weeks -						
9/28/74	163	80	110/70	38-1/2	30	41
10/19/74	159	76	110/70	38	29	40
12/14/74	155	84	110/70	38	27-1/2	39-1/2

In summary, this patient lost 61-1/2 pounds in 40 weeks, an average of a little more than a pound and a half a week, and she is still losing. Her initial symptoms of headaches and excessive fatigue have completely disappeared. Her acne has entirely cleared, as well.

Patient No. 4 was hypoglycemic and hypothyroid, and was 48 years old when she first came for help with her excess weight. She'd had a problem since her teens and had recently tried to get help from the group clinic she belonged to. Without making any tests or even taking a careful history, the doctor just said, "You have to have will power and push yourself away from the table."

Actually she was eating a good basic diet - adequate protein, vegetables and fruit. But in addition she was eating too much starches. Besides her overweight of at least 75 pounds (she is only four feet eleven inches tall and weighed 180), she was excessively tired most of the time and very sensitive to cold, and her elbows were quite dry. Otherwise, her physical examination and vital signs were normal. The PBI (thyroid test) was quite low (3.0 mcg%), cholesterol was very high (460 mgm%), and the one hour post-prandial glucose test was 220 mgm%. The low thyroid and high cholesterol tests along with the excessive fatigue, dry skin and overweight pointed to the diagnosis of hypothyroidism. And the excessive intake of starches and the high blood sugar test (one hour after drinking Glucola) suggested the diagnosis of hypoglycemia and borderline diabetes.

Patient No. 4 was given thyroid and told to eat a hypoglycemic diet, as she was suspected of being hypoglycemic. This way of eating greatly reduced her desire for starches and, as can be seen from the table which follows, the treatment has worked beautifully for her. She noticed at once that she felt more energetic. This change was partly the result of the increased amount of energy made available as a result of taking thyroid, and partly due to the fact that the high protein diet kept her blood sugar from falling into the hypoglycemic range as was frequently happening before.

<u>Date</u>	<u>Weight</u>	<u>Pulse</u>	<u>Blood Pressure</u>	<u>Bust</u>	<u>Waist</u>	<u>Hips</u>
5/3/74	180	80	140/90	45-1/2	38	46
5/31/74	165	80	140/90	42	34	42
6/28/74	157	84	130/80	42	33-1/2	41-1/2
7/26/74	152	80	130/90	41	33	40-1/2
8/30/74	147	80	140/90	40	33	40
10/15/74	141	80	130/90	39	31-1/2	48
- Off treatment two weeks -						
11/12/74	142	80	130/90	39	32	38-1/2
12/10/74	138	80	130/90	39	31	38

As shown, twenty-eight weeks of treatment resulted in forty-three pounds of weight loss.

It is well known that diabetes is a very serious disease which occurs frequently in the latter decades of life. What is not so widely realized is that hypoglycemia is a precursor of diabetics. And diabetes causes severe hardening of the arteries, which in turn causes coronaries, strokes, high blood pressure, blindness, and so on. Clearly the control of hypoglycemia is also a very significant way of delaying the aging process. Though at the time of writing this paper neither Patient No. 3 nor Patient No. 4 has reached her weight goal, it is clear that they need only to continue eating as they do (and continue taking thyroid) to reach their weight goals, stay at that weight permanently and probably avoid becoming diabetic and so live normal life spans.

Since both patients have now learned to eat in a way that makes it easy to control their consumption of refined sugars and starches, their chances of becoming diabetics are greatly reduced. Of course each of them will also need to take thyroid for the rest of their lives. And when the menopause occurs they should begin to take estrogens to replace the endocrine hormones no longer provided by their own ovaries.

Summary and Conclusion

The major advances of medicine and surgery have been in the direction of preventing deaths in the early years of life from contagious and infectious diseases. But too many of those who now live beyond forty are not living very much longer than most people did a century ago. They should be.

I think you'll agree that these four cases demonstrate that it is already possible to control and even reverse some of the most important pre-disease conditions associated with the aging process - overweight, hypertension, arteriosclerosis, hypoglycemia, diabetes, osteoporosis (bone degeneration) and others. Clearly, medical science now has the knowledge and ability to really extend the length of healthy vigorous life for most people over 40 and thereby help most of them to live in a state of health to 70, 80 or 90 or even more.*

* An excellent book, "Don't Give Up On An Aging Parent", by Lawrence Galton, has just been published. It gives a great deal of information about these possibilities.

So what is needed? Only this. People who wish to live as long as possible in a state of health and vigor must find and use the advice of those few* physicians who are interested in practicing Personal Preventive Medicine and in using nutritional and health education as means of preventing premature degeneration and thereby slowing down the advance of aging.

*. The vast majority of physicians are trained to diagnose and treat organic diseases after they have occurred. And most of them are very good at and very busy doing that. But they do not consider overweight, excessive fatigue and most of the other signs and symptoms of hypoglycemia and mild hypothyroidism to be organic diseases. These comments are not intended as criticism. They merely recognize one of the basic facts about modern medical practices. Only a relatively few (probably no more than 5,000) physicians in the United States have received the kinds of specialized preventive education and training that qualify them to practice personal preventive medicine.

THE UNIVERSITY OF IOWA

IOWA CITY, IOWA 52242



Department of Psychiatry-Alcoholism Studies
State Psychopathic Hospital
500 Newton Road

July 13, 1976

Mr. Jimmy Carter
Carter Presidential Campaign
Plains, Georgia 31780

Dear Mr. Carter:

Congratulations on your nomination. I am enclosing three papers hoping they might provide some small input into your planning for health services, particularly with regard to the problem of alcohol and drug abuse. Iowa's experience of the past decade developing alcoholism programs supports your view that revenue sharing should go directly to local communities rather than to the state. This is especially true regarding a social problem such as alcohol abuse where there is no proven solution to be directed from the top down and no "bottom line" against which to judge performance of the program. The only hope for progress is local citizens working toward their own solutions.

Over a period of some eight years, beginning in 1966, many local Iowa communities established voluntary, non-profit citizens' groups to come to grips with the alcohol abuse problem and to find more effective, efficient, and humane ways of helping alcoholics rehabilitate themselves and to reduce further alcohol abuse. The enclosed reports indicate their progress.

About two years ago the state, using state and federal funds, began "buying up" the local service centers and imposing control. The results of the state take-over to date has been the creation of another costly bureaucracy at the expense of local citizen participation and control, but with no added benefits to the alcoholics of the state or to the taxpayers.

Total expenditures for alcohol programs which was \$2.8 million in 1974, have nearly doubled with little, if any, increase in the number of alcoholics being served. And we know the effectiveness of the services has not increased because no one knows how to do that.

Alcohol abuse is one of those problems that cannot be solved, but progress in that direction can only be made by engaging the people in a self-help program. If the state has a role to play, it is to provide competent leadership (as opposed to directorship), and technical assistance to local committees helping them to define their own problem in their own way, and work out their own solution. The best model to follow would be the agricultural county extension agent concept.

If I can be of service to you, please let me know.

Respectfully yours,

Harold A. Mulford
Harold A. Mulford, Ph.D., Professor and Director

HAM/la

over for response

Dear Dr. Mulford-

Thank you for your letter of July 13. Governor 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.

I appreciate your assistance and interest in the Carter Campaign. I am currently preparing ^{a book for} the Governor on the problems of alcoholism & drug abuse, and the information you send is most helpful. Any further material you might wish to send would be appreciated. Our campaign address is

PO Box 1976
Athens, Ga 30301

Thanks again for your help.

Sincerely,
Robert S. Harty
Natalie Ann & Paul

August 16, 1976

Dr. Harold A. Mulford
The University of Iowa
Department of Psychiatry
500 Newton Road
Iowa City, Iowa 52242

Dear Dr. Mulford:

Thank you for your letter of July 13. 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 assistance and interest in the Carter campaign. I am currently preparing a briefing for the Governor on the problems of alcoholism and drug abuse and the information you sent is most helpful. Any further material you might wish to send would be appreciated.

Thank you for your help and interest.

Sincerely,

Robert S. Havely
National Issues and Policies

RSH:dan

August 10, 1976

Mr. David A. V. Reynolds
Director
Northern Counties Health Council
Box 388
St. Johnsbury, Vermont 05819

Dear Mr. Reynolds:

Thank you for your letter of July 28. Stu Eizenstat has referred your letter to me as I will be handling health care issues for the campaign on the staff level.

Governor Carter shares your concern for making medical care accessible as well as affordable. I am enclosing a copy of the Governor's remarks before the Student National Medical Association, in which he outlines his thoughts on delivery system reform, maldistribution, and National Health Insurance. After you look over the Governor's speech, you may have additional ideas or suggestions. I would be pleased to have your reactions to this material.

Mary King is our task force leader for health care and she may be reached at our Washington office at 1625 Massachusetts Avenue, N.W. Either Mary or I would be delighted to have the benefit of your thinking in this area.

Thanks again for writing. I look forward to hearing from you.

Sincerely,

Bob Havely
National Issues and Policies

BH:dan



Bob

NORTHERN COUNTIES HEALTH COUNCIL

COMPREHENSIVE HEALTH PLANNING

FOR NORTHEASTERN VERMONT AND NORTHERN NEW HAMPSHIRE

July 28, 1976

Governor Jimmy Carter
Jimmy Carter Campaign Headquarters
Colony Square, NE.
Atlanta, Georgia 30361 - Attention: Stuart Eizenstat

Dear Governor Carter:

I am writing because I have followed your progress with interest and enthusiasm. Specifically, I have been impressed with your willingness to seek the opinions of persons from outside the usual Washington, New York, and Boston orbits. Therefore, I am hopeful that my completely unsolicited views may merit some consideration.

First, I feel that I should provide you with a little of my background. Following a year in Florida as a VISTA Volunteer, I received a Master's Degree in Public Health from the University of Michigan in the field of Medical Care Organization. While at Michigan, I completed course work in National Health Insurance under former Secretary of HEW, Wilbur Cohen. Since that time, I have been employed as the Executive Director of a health planning agency in an extremely rural area of Vermont and New Hampshire. Currently, I am involved in establishing comprehensive health centers in two areas of this region, which chronically have lacked health services. My reason for writing is to share with you some of my concerns regarding the financing and delivery of health services, particularly as they affect rural areas.

It seems that in most discussions about proposed National Health Insurance, the focus tends to be only on the financing of such a system. While this is obviously a crucial issue, concentration on it tends to minimize discussion on the other elements which affect access to health care. I believe the debate on National Health Insurance must be expanded to include a consideration of the problems of maldistribution of manpower and services. If this does not occur, the American public, and particularly that portion of the American public which resides in rural areas, will be extremely disillusioned and angered, when, despite having medical care paid for, that care remains unavailable.

An example of this problem in our area has been the Medicare program. Northeastern Vermont has an elderly population significantly higher than nationally. Thus, the passage of Medicare was seen as offering widespread benefits to this population in terms of health services. However, because it is basically a financing system, Medicare did nothing to encourage the redistribution of services into this area. Consequently, having the ability to pay for services has not necessarily meant that the elderly population in Northeastern Vermont have obtained such services. Similarly, if we are not ready and able to address the larger, more sensitive issues of how and where medical care is delivered in this country, I believe that National Health Insurance will ultimately be a failure.

I understand that Ms. Mary King is heading a task force for the Carter campaign dealing with National Health Insurance. I would hope that my concerns would be shared with her; and furthermore, I would welcome the opportunity to be involved in this task force's discussions as it explores the possible solutions to the problems of bringing better health care to all Americans.

I thank you for your attention.

Sincerely,



David A. V. Reynolds
Director

DAR:ds

August 18, 1976

Mr. W. Robert Friedman, Jr.
Research Department
L.F. Rothschild & Company
99 William Street
New York, New York 10038

Dear Mr. Friedman:

Thank you for your letter to Stu Eizenstat of August 4. Stu has forwarded it to me; I am in charge of health issues on the staff level for the campaign.

I appreciate the materials you sent along. I am enclosing for your review a speech on national health policy which outlines Governor Carter's philosophy on cost controls, access to medical care, and National Health Insurance. I would appreciate having your thoughts on the Governor's approach to these problems.

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
National Issues & Policy

RSH/lk

Bob H.

46 Justamere Drive
Ossining, N. Y. 10562
August 4, 1976

Mr. Stuart Eizenstat
Carter-Mondale Presidential Campaign
100 Colony Square
Atlanta, Georgia 30309

Dear Mr. Eizenstat:

I understand that you are responsible for overseeing Governor Carter's advisory task force. Consequently, I am writing you, ~~directly~~, with the hope that the information I have enclosed regarding our national health care policy will eventually reach the proper individual(s).

As a security analyst, with L.F. Rothschild & Co., I have been doing in-depth analysis of the health care industry for the past several years. During this time, health care costs have risen rapidly and I have noted the acute impact this is having on health care institutions. It is from my vantage point as an industry analyst as well as a concerned citizen that I am writing you pertaining to Governor Carter's health care proposals. Obviously, I have no knowledge as to which one of the may National Health Insurance proposals he will favor should he be elected. Moreover, that is not significant. Most agree some form of NHI plan is needed: however, how the program is implemented and its impact on the country is of major importance.

The point I hope your task force will focus on is that the nation has only finite resources to devote to what could prove to be an area of infinite demand. Given this, the key health care question then becomes exactly how much of our resources will you be willing to spend on health care versus other sectors of the economy.

August 4, 1976

Health care spending is now increasing at a 15% annual rate, and Government estimates indicate that, at current policy levels, without any additional programs, if this rate of growth continues we will, within the next 3 - 4 years, spend over \$255 billion, close to 12% of the GNP. Can our nation afford this, given the other pressing societal problems that must also be addressed by any administration?

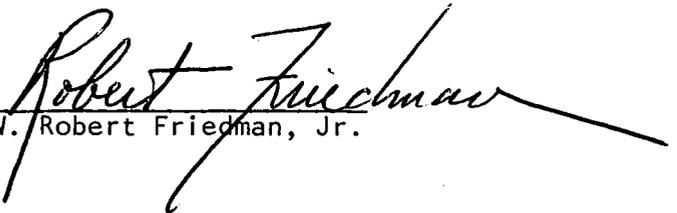
There is little doubt that too many Americans lack ready access to our health care system and are not receiving the proper care. But I seriously hope that you and your advisors will consider how best to balance the potentially unlimited demand for health care with the fact only finite resources are available to meet it. Within this context, I hope you will also direct your health care task force to examine what long range structural changes must be made to optimize the breakeven between more evenhanded health care benefits and the need to avoid excessive inflation of the total Federal Budget.

I would appreciate it if you or a member of your staff would inform me of the proper contact within your organization. I would be pleased to provide whatever help I can to you or your organization regarding the foregoing and can be reached in New York at L. F. Rothschild & Co.

Research Department
99 William Street
New York, N. Y. 10038

(212) 425-3300

Sincerely,


W. Robert Friedman, Jr.

WRF/cs
encl.

DATE 7 HOUR 1

TO Bob Havelly

WHILE YOU WERE OUT

M Richard Wilson, Prof.

OF Ga. Tech Architecture

home 233 1375

PHONE AREA CODE PHONE NUMBER

TELEPHONED	<input checked="" type="checkbox"/>	RETURNED CALL	<input checked="" type="checkbox"/>	LEFT PACKAGE	<input checked="" type="checkbox"/>
PLEASE CALL	<input checked="" type="checkbox"/>	WAS IN	<input type="checkbox"/>	PLEASE SEE ME	<input type="checkbox"/>
WILL CALL AGAIN	<input checked="" type="checkbox"/>	WILL RETURN	<input type="checkbox"/>	IMPORTANT	<input checked="" type="checkbox"/>

MESSAGE * FALL QUARTER * SEMINARS

Tech 894-4885

concerning prog of health facilities - wants you to speak at his school - I warned him that you were preparing for debates -

SIGNED JS Someone recom.

Sep 29. Wed. Area-wide
Planning - Health Serv.
Agencies (HSA)

Oct 6. Wed. Modes of delivery
of ambulatory care, inc.
HMO's.

Oct 25. Monday - Mental Health.

Nov 1. Monday - MIMS
emergency group.

3 Nov. Wed - Health
education

4:15 P.M. GOV'T. PHILOSO.
+ LEGISLATION.

GEORGIA INSTITUTE OF TECHNOLOGY
ATLANTA, GEORGIA 30332

COLLEGE OF
ARCHITECTURE

September 15, 1976

Dr. Robert Havelly
Carter Mondale Headquarters
Colony Square
Atlanta, Georgia 30361

ATTENTION: "ISSUES"

SUBJECT: GRADUATE PROGRAM IN HEALTH FACILITY PLANNING AND
DESIGN

Dear Dr. Havelly,

I am writing to express our sincere appreciation of your kind offer to address our Fall Quarter graduate students on the subject of "Trends and Developments in Ambulatory Health Care Delivery Systems, Facilities Planning, and Design."

The class will meet from 1:30 to 5:00 p.m., Wednesday, October 6, in Room 528 of the Price Gilbert Library at Georgia Tech.

We look forward to seeing you at about 4:15 as discussed.

Yours sincerely,



Richard Wilson
Professor

PS The attached outline has been prepared to cover a number of points in several major aspects of ambulatory care services and facility planning and will serve as a study guide for several of our seminars. Its possible relationship to the seminar of October 6 is suggested on Page 2.

RW:dm

Enclosure: Outline

*I also enclose a copy of an article we wrote for
Architecture in Greece this year — with some passages
that might interest you, marked on pgs 136, 137, & 188 thru 192.
Our students will have read this article before the day
of our seminar. RW.*

July 21, 1976

Mr. Stu Eisenstadt
Atlanta, Ga.

Dear Stu:

I am taking the liberty of writing directly to you, to suggest some technicalities related to the financing of National Health Insurance. As you know, I have been writing step-by-step briefing papers for Mary King, on how to systematically consolidate existing programs, to form the nucleus of NHI, etc. This letter is supplemental to those papers already "in the system".

First, basic policy/political questions that I am being asked by key staff experts from the Library of Congress, who do health insurance research for the House and Senate, include:

1) Will Carter delineate between pure health matters in establishing and funding NHI, ie, will he separate health from social/welfare issues? Example: Some Hill people view home-bound home-maker services in support of health, whereas others view such work as a part of the total health services spectrum. This is a major "sticking point" that the Republicans are preparing to jump on, this Fall, from what I hear. They will try to smear us with expanding the "welfare mess" unless we can clearly delineate health services from so-called social welfare services to the same clients.

2) As I am putting together an independent study on the costs/funding of a future NHI Plan, it occurs to me that the insurance (health) companies could accuse us of depleting the cash reserve they now earn from health premiums, which cash reserve they use in mortgage loans in the construction market. IF this is a logical assault, we should be prepared to explain how we (the Federal National Health Insurance Plan) will not negatively impact the money supply for mortgages, be they construction mortgages or home buyer/ long term commercial mortgages.

I may be wrong but it's worth exploring

At a future date, when you are up here in D.C., would appreciate the opportunity to brief you and Mary jointly on where I am in researching this whole area of NHI. I expect to meet soon with a lady on the National Citizens Health Insurance Committee, at the suggestion of Mary King.

Mary King is a real asset up here, as is Peter Bourne. We are really lucky to have such intelligent and quality people at this end.

Cordially,



George Singleton, 11803 Breton Court, Reston, VA. 22090

August 16, 1976

Ms. Mary K. Whigham
P. O. Box 726
Young Harris College
Young Harris, Georgia

Dear Ms. Whigham:

Thank you for your letter to Governor Carter.

Governor Carter believes that possession of small amounts of marijuana should be a civil, not a criminal offense, and that the matter should be resolved by individual states. He feels, however, that vigorous prosecution of dealers and pushers is essential.

Sincerely,

Robert S. Havely
National Issues and Policies

RSH:dan

P.O. Box 1726
Young Harris
College
Young Harris,
Georgia
June 26, 1976

The Honorable Jimmy Carter
Plains, Georgia

Dear Honorable Carter:

I am very concerned about the fact that marijuana may one day be legalized. Considering the fact that liquor and cigarettes have caused much damage to our society. I truly would appreciate a letter from you stating your opinions on the issue for my own interest and a prerequisite grade.

I personally feel the legalization of marijuana would be unhealthy and dangerous for our society. How about you? Looking forward to hearing from you.

Yours very truly,

Mary Kathleen
Whigham

P.S. - Best of luck in the election!

Thanks for letter, etc. Decriminalization, not
legalization; up to states. Vigorous
prosecution of pushers & dealers. Sincerely,
(2) RW

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



Leaders, for a change.

September 23, 1976

Joseph S. Gordon, M.D.
4017 Garrett Road
Drexel Hill, PA 19026

Dear Dr. Gordon:

Thank you for your letter of July 19, and I apologize that it has taken so long to reply. Governor Carter has referred it to me as I will be handling health issues on the staff level during the campaign.

Governor Carter shares your concern about the problems involved in preventive medicine. I am enclosing a copy of the Governor's remarks before the Student National Medical Association in which he outlines his thoughts on this issue. After you look over the speech, you may have additional ideas or suggestions. I would be pleased to have your reactions to the material.

Thank you again for your help and interest.

Sincerely,

Robert S. Havely
Health Issues Coordinator
National Issues and Policy

RSH/sw

Enc.



Issues
DEPT

JOSEPH S. GORDON, M.D., P.C.
INTERNAL MEDICINE
4017 GARRETT ROAD
DREXEL HILL, PENNA. 19026

Telephones MA 3-0186
1734-1760

7/19/76

Mr. Jimmy Carter
1421 Walnut St.
Phila., Pa. 19102

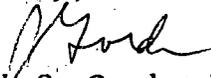
Dear Mr. Carter,

Now that you are the Democratic candidate for president of the United States, I feel that I must write you concerning two specific problems. In the A.M.A. News recently, you stated that medical priorities should be concerned with preventative medicine. As you know, the yield in preventative medicine is quite small and the cost would be enormous. Since heart disease, cancer and stroke can not be eliminated by legislation, priorities ought to be given towards the changing of the human life style of our American citizens. Specifically, tobacco, elimination of the pollution in air and water as well as food additives which may lead to malignancies. This is an enormous project but one which you would have to do, and yet would be far cheaper than just doing preventative examinations on the entire population of this country.

The sooner politicians realize that health can not be legislated the better off our health dollars will be spent in the United States of America. I realize you have an enormous task if you are elected president to get rid of the special interests in tobacco, in food additives and in alcohol. We of the medical profession will try to educate our patients but you must remember that well over 70% of all patients do not follow the doctor's advice concerning life style any way. And to this end, legislation for national health insurance will not benefit the vast majority of our population. It will add a cost far and away greater than the benefit yielded for our citizens.

I urge you to consider these comments carefully before you consider any legislative program which will plunge our country into enormous debt from which we would have staggering effects.

Cordially,



Joseph S. Gordon M.D.

JS /lu

Thank for letter &
send copy of
health care
speed.

Forward to
Committee
Jan 8

September 8, 1976

Mr. Roger Schmeeckle
20 Franklin Street
Barre, Vermont 05641

Dear Mr. Schmeeckle:

Thank you for your letter of September 2. I have responsibility for health issues, including abortion, and I was pleased to have your constructive suggestions and kind words of support.

Abortion is an extremely difficult issue, and Governor Carter's position, which has remained consistent for years, is complex. He is opposed to abortion, and was successful in establishing in Georgia an effective voluntary family planning program to minimize the need for abortion. While he personally does not believe the Constitution is the proper forum in which to address this issue, he believes it would be inappropriate for any citizen to be deprived of the right to seek an amendment to the Constitution.

I agree that many of the Governor's positions should merit the consideration of those concerned with human dignity and the value of life and justice. Hopefully, that perspective will be maintained throughout the campaign.

I appreciate your taking the time to send me your thoughts on the subject, and I have incorporated several of the themes you raised into staff briefing materials now in preparation.

Mr. Schmeeckle
Page Two
September 8, 1976

If you have further comments or ideas, please
send them along.

Sincerely,

Robert S. Havely
Health Issues Coordinator
National Issues and Policy

RSH:fh

20 Franklin Street
Barre, Vermont 05641
September 2, 1976
(802) 479-2298

Issues Staff
Carter Headquarters
P.O. Box 1976
Atlanta, Georgia 30301

Dear Sirs:

I am a Carter supporter and a loyal Catholic. I support a constitutional amendment to ban abortion. Nevertheless, I view with alarm any sign of strained relations between Carter and the Catholic hierarchy. With so many points of common concern, it would be most unfortunate if subtle differences with regard to the problem of abortion were to be exaggerated out of all due proportion.

With regard to defending Candidate Carter's position on a constitutional amendment banning abortion, I suggest the following principles to promote a relationship with the Catholic bishops that will be mutually valuable:

- 1) Disregard for the sanctity of life is a deplorable fact of modern society.
- 2) Nevertheless, it is uncertain that employing the police powers of the state to suppress abortion is prudent, given the widespread social acceptance of abortion. ("Prudent" is the right word to use here, because of its connotations in moral theology).
- 3) There are many other ways besides supporting a constitutional amendment, some of them perhaps more effective, in which a president can encourage respect for the sanctity of life.
- 4) An amendment to give states "local option," said to be supported by Ford, would not substantially alter the present situation, for it would be easy to circumvent the prohibition in some states by traveling to others which permitted it.
- 5) With regard to the proposal to ban all terminations of pregnancy, there are seemingly legitimate reservations, based on the individual's right to defend his life, about situations in which a mother's life is seriously threatened. (No other reservation, in my opinion, is likely to cut any ice with the bishops).
- 6) Ford's overtures to the bishops are suspect in view of his record of doing nothing so far.
- 7) While recognizing the right and the duty of the bishops to promote a constitutional amendment, it would be unfortunate if their relationship to the candidates were to be governed by only one issue, without regard to the candidates' records and positions on civil rights, aid to the poor, the arms race, etc.

I assume that Carter is soliciting advice from some qualified Catholics on this and related issues. I would particularly recommend, if he has not already done so, that a connection be established with Rev. Hesburgh, President of Notre Dame, who might suggest others.

I trust that you will give these ideas your consideration and refer them to Jimmy Carter if it seems appropriate.

Sincerely, Roger Schmeeckle

Roger Schmeeckle
20 Franklin St.
Barre, VT 05641

Not pls file

August 6, 1976

Mr. Wesley Hill
1015 Chestnut Street - Suite 1100
Philadelphia, Pennsylvania 19107

Dear Mr. Hill:

Thank you for your mailgram of July 26. I have responsibility on the staff level for health care and related issues, and I would be pleased to have the benefit of your thoughts and advice for use in providing materials for Governor Carter.

Looking forward to hearing from you.

Sincerely,

Robert S. Havely

RSH/lk

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Issues

JIMMY CARTER
PLAINS GA 31780

I CONSIDER IT VERY IMPORTANT TO COMMUNICATE WITH YOU ABOUT YOUR PROPOSALS FOR HEALTH CARE UNDER YOUR ADMINISTRATION. HOW CAN I GET THROUGH ALL OF YOUR MAIL IN TIME FOR YOU TO REVIEW IT BEFORE NOVEMBER. ANXIOUSLY WAITING YOUR INSTRUCTIONS.

WESLEY HILL
TELEPHONE 215/574/8057
1015 CHESTNUT ST SUITE 1100
PHILADELPHIA PA 19107

1611 EST

MGMCOMP MGM

Dear Mr. Hill:

④ Thank you for your mailgram of July 26. I have responsibility on the staff level for health-care and related issues, and I would be pleased to have the benefit of your thoughts and advice for use in providing materials for Governor Carter.

④ Looking forward to hearing from you.

*Sincerely,
Robert S. Hawley*

TO REPLY BY MAILGRAM, PHONE WESTERN UNION TOLL FREE ANY TIME, DAY OR NIGHT:

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Areas 212, 516 & 914	800 257 2211
Except Manhattan	962 7111
Bronx	962 7111
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WEST VIRGINIA	800 257 2221
WISCONSIN	800 325 5200
WYOMING	800 648 4500

OR DIAL WESTERN UNION'S INFOMASTER SYSTEM DIRECTLY:

FROM TELEX 6161

FROM TWX 910 420 1212

234 Quail Ave.
Sebring, Fla. 33870
June 13, 1976

Phone: 1-813-385-7497

Thanks for letter;
Gov Carter is
concerned about
problem, etc.
Appreciate
your
thoughts.
Sincerely,
EAP

Mr. James Carter
P.O. Box 1976
Atlanta, Ga. 30301

RE: carcinogen--cancer causing
agents in our food

Mr. James Carter
Plains, Ga.

Dear Sir:

Re the above captioned subject I wish to remind you in a helpful manner that Gerald Ford has had over twenty five years in the House plus the Presidential ~~period~~ period to do something positive about removing the carcinogenic substances in practically all of our foods we have to ingest into our bodies.

Jaime Friedman from Washington D.C., page one February 7 edition of The National Observer writes an article titled "Is Bacon A Cause Of Cancer":

" for hundreds of years nitrite has been used to cure bacon & give it its characteristic color & flavor. Only recently has it been discovered that the nitrite, under the heat of frying, combines with the ~~nit~~ amines of the meat protein to produce a deadly type of "nitrosamine" called nitrosopyrrolidine--a compound that consistently produces cancer in laboratory animals."

Read the foodstuffs in the supermarkets. They all contain all sorts of chemicals such as sodium diacetate, sodium propionate, methycellulose, sodium caseinate lecithin, disodium dihydrogen pyrophosphate, sodium alginate, propylen glycol, potassium sorbate, sodium benzoate, butulated hydroxytoluene, sorbitan monostearate, red dye 2 (recently banded by F D A), mono and di-glycerides etc etc.

Dr. Bruse Ames, aleading cancer researcher and professor of biochemistry at the University of California at Berkeley said on page 3 June 1, 1976 National Enquirer: " We know a lot about what kinds of chemicals cause cancer. . . . " "It's absolutely incredible that such substances are ever allowed on the market." "Unfortunately, there's no law requireing industry to test its own products."

Page 53 same newspaper has article re "Drug Companies Continue to Distort & Falsify Reports on Products That Could Cause Cancer" Senator Gaylord Nelson (D-Wisconsin) and Senator Edward Kennedy (D-Mass.) are calling for a probe of the entire drug industry.

Go get them, Mr Carter and you'll enjoy the biggest VOTING LANDSLIDE IN OUR NATIONS HISTORY!

Sincerely,

Edward A Pugnier
Edward A Pugnier

EAP
cc Plains, Ga

August 16, 1976

Mr. Edward A. Pugnier
234 Quail Avenue
Sebring, Florida 33870

Dear Mr. Pugnier:

Thank you for your letter to Governor Carter.

The Governor is concerned about the problem which you mentioned and appreciates your thoughts on the issue.

Your interest is greatly appreciated.

Sincerely,

Robert S. Havelly
National Issues and Policies

RSH:dan



Jimmy Carter

Presidential Campaign

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

August 16, 1976

Mrs. John R. Anderson
187 West Lincoln Avenue
Delaware, Ohio 43015

Dear Mrs. Anderson:

Thank you for your letter to Governor Carter.

Governor Carter is a deeply religious man who believes that moderate, decent Christian behavior is central to restoration and preservation of our important values.

Governor Carter believes that possession of small amounts of marijuana should be a civil, not a criminal, offense, and that the matter should be resolved by individual states. He feels, however, that vigorous prosecution of dealers and pushers is essential.

Thank you for your interest.

Sincerely,

Robert S. Havely
National Issues and Policies

RSH:dan

Please Turn Page -

Dear Mr. Havely:

Thank you for your answer.

Might I just add that if Mr. Carter expects to win in November, he best not make such liberal statements as Blanket Pardon . The average public does not understand. As my son- Phi Beta Kappa senior college student- said-- President Roosevelt was smart enough to maintain quite a conservative view UNTIL he got into the White House and then he implemented several more liberal reforms for the good of the nation. I just wish Mr. Carter could join our Dinner table discussions. I've listened to many and also I definitely am not being prejudice because everyone states how unusual my two sons are. They speak even away beyond my years. God has blessed them both and I have faith if they are to be heard in this world they will be heard.

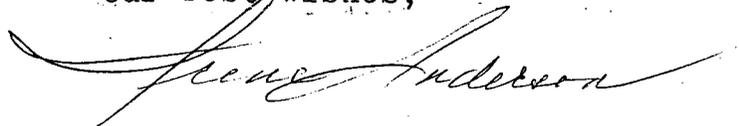
We feel Mr. Carter has slipped in his speech delivery as well. Many of the finest rated speech professors are superficial and artificial I just wish I could coach Mr. Carter regarding his delivery. He should practice more each day on lip and jaw exercises-- cease his low placed gestures-- and "speak from the heart"...

Mr. Mondale equally had better pay more attention to delivery. He needs to learn to speak from the diaphragm-- his voice is strained and shallow-- thus- his personality comes across this way. He should practice diaphragmatic breathing.. this would help with relaxation as well as speech.

The T V audience is a critical one-- it's unfair in a way-- when issues, sincerity- ability--are so much more important - but in today's world, we can not overlook the importance of presentation as well as what is being presented.

We would like to see Mr. Carter win--but we shall be listening. Your strategy has certainly been excellent thus far-- as we hope your sincerity-- but there seems to be a change. It would be a shame to be so near success-- when it is so needed and not have it realized !

Our best wishes,

A handwritten signature in cursive script, appearing to read "Jean Anderson". The signature is written in dark ink and is positioned above the typed name.

(Mrs. John Anderson)

rec'd ples file marijuana

August 6, 1976

Dorris M. Shrubsall
8416 Pershing Avenue
Niagara Falls, New York 14304

Dear Mrs. Shrubsall:

Thank you for your letter of July 30. Helen Mills has referred it to me for review. Governor Carter favors the decriminalization -- not legalization -- of marijuana possession, along the lines of the Oregon law passed recently. He favors this decriminalization on a state-by-state basis, as opposed to federal intervention in this area.

The Governor believes that persons selling drugs or possessing more than one ounce of marijuana should still be subject to criminal penalties. This approach provides the advantage of easing the burden on young people for owning small amounts of marijuana while allowing a vigorous attack on the sellers of large quantities.

I hope this explanation makes Governor Carter's position clear on this issue.

Helen tells me that you and your husband have been extremely helpful in New York, and we appreciate your continued interest in, and support of, Jimmy's campaign. If I can be of further assistance, please don't hesitate to write.

Sincerely,

Bob Havely
National Issues & Policy

BH/lk

8416 Gerking Avenue
Magara Falls, N.Y.
July 30, 1976

Dear Helen,

Just some additional information that Jimmy Carter should be aware of. We have just learned from published accounts of Jimmy Carter's stand on various issues that he is in favor of decriminalization of marijuana. We wish you would bring the enclosed newspaper article to his attention since it reveals the true strategy behind such a move, and since this strategy involves southern farm land, a southern university and southern manufacture of liquor and tobacco, it could lead to some embarrassment for him during the coming "Sixty Four Campaign". It is, in our opinion, an open invitation for what we northerners refer to as the "Nepot" to become involved

in a legalized drug with such a high resale
value. As you know, in the past and
present they are involved in many so-
called "legitimate businesses" on the surface
of things.

Sincerely,

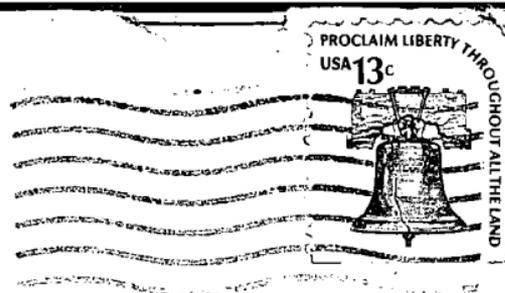
Dennis Shuckall

P.S. I need a new Carter - Mondale
sign for my house - or a couple
of them. Can you send me some.

I'll drop you another line soon.

Dorris M. Shrubbsall
8416 Pershing Avenue
Niagara Falls, N.Y. 14304

Kitty ISSUES



Dear Kitty,
Would you please
answer Dorris?
She & her
husband have
been very
helpful in NY.
to Jimmy,
Helen

Ms. Helen Mills

44 Putnam Drive

Atlanta Ga. 30342