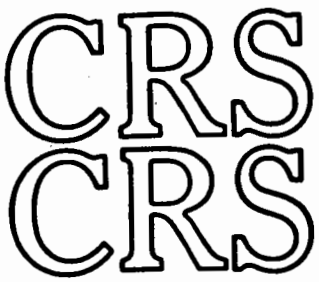
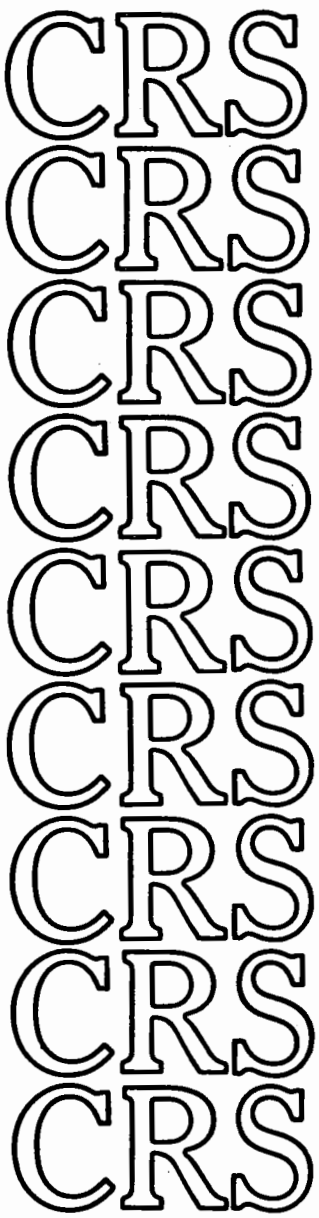
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ISSUE DEFINITION

The purpose of the Clean Air Act is "to protect and enhance the quality of the Nation's air resources... ." To achieve this purpose, the Environmental Protection Agency (EPA) is required to establish air-quality standards, and each State must develop a plan to achieve and maintain these standards. The courts subsequently determined that the intent underlying the Act included preventing the air (where it is currently cleaner than standards) from deteriorating "significantly." The issue is whether EPA's regulations are in keeping with the intent of Congress and provide adequate protection of the general welfare, including crop production and other economic activities.

BACKGROUND AND POLICY ANALYSIS

The Environmental Protection Agency (EPA) has promulgated national primary and secondary ambient air-quality standards as prescribed by the Clean Air Act of 1970 (P.L. 91-604). The primary standards were set at a level that protects the public health; secondary standards were set at a level that protects the general welfare from any known or anticipated adverse effects. Implementation plans to attain and maintain these standards have been submitted by all the States.

The Sierra Club and other groups questioned EPA's interpretation of the language of the Clean Air Act, and contended that the implementation plans did not fulfill the requirements for preventing significant deterioration as identified in Section 101(b) of the Act.

Section 101(b) states that one basic purpose is "to protect and enhance the quality of the Nations's air resources so as to promote the public health and welfare and the productive capacity of its population." The Senate report accompanying the bill (which became the Clean Air Act of 1970) supports the view of the Sierra Club.

The courts affirmed the view of the Sierra Club and ordered the Administrator of EPA to review all implementation plans and disapprove any plan that failed to prevent significant deterioration effectively. In addition, he was ordered to promulgate regulations to prevent significant deterioration of air quality.

Regulations promulgated by EPA on Dec. 5, 1974, call for establishment of "classes" of varying incremental increases in total suspended particulates (TSP) and sulfur dioxide. Class I applies to areas in which almost no change in air quality levels would be allowed. Class II applies to areas where moderate change would be allowed, but where stringent air quality constraints would be imposed. Class III applies to areas where air quality would be allowed to deteriorate down to national standards.

The Sierra Club stresses that the current EPA regulations are inadequate. It contends that the major deficiencies are:

(1) They cover only two pollutants, particulates and sulfur dioxide, instead of the six pollutants covered by primary and secondary standards.

(2) In defining the area classification, Class III areas would be allowed to deteriorate to levels of the secondary standards. In the worst case, the Sierra Club claims that all States could request that clean air areas be reclassified to Class III, thereby rendering a no-significant deterioration meaningless.

(3) The list of pollution sources covered by the regulations is incomplete and the exemption of some sources from the requirement of best available control technology does not fit the purpose of the regulation.

Industry views the regulations as a "no-growth policy" that will preclude the development of the vast energy resources of the nation. They contend that:

(1) Primary and secondary air quality standards and new source performance standards will protect public health and welfare.

(2) The no-significant deterioration regulation would enlarge the Federal regulatory powers at the expense of a State to determine its own plan for development as well as economic and social progress.

(3) Under this policy the States would lose their ability to resolve their own destinies.

These arguments are in conflict with those of the 16 States which maintain that concentrations of air pollutants at or near secondary standards would produce such effects as to seriously threaten, if not destroy, their current economic base. (Amici Curiae Brief in support of Respondents: Alabama, Connecticut, Florida, Kansas, Louisiana, Maine, Massachusetts, New Mexico, New York. North Carolina, Ohio, Oregon, Pennsylvania, South Dakota, Texas, and Vermont; Supreme Court of the United States, Ruckelshaus v. Sierra Club No. 72-804.)

Although industry contends that primary and secondary standards are adequate to protect health and welfare, the Sierra Club stresses that the reasons for preventing significant deterioration of air quality are "most compelling." It calls attention to the impact of allowing deterioration down to secondary standards by stressing that unless air quality is maintained, cherished places like the Grand Canyon, the Rockies, the Smokies, and the Everglades could eventually have air quality equivalent to what exists now in downtown Boston, Akron, Detroit, or Pittsburgh. Visibility would be reduced from 80 or 100 miles to 12 miles or less.

Cubia Clayton, Chief of the Air Quality Division, New Mexico Environmental Improvement Association, tells a similar story. When describing the impact of the Four Corners Power Plant, he stated that visibility of 80 miles had been accepted in New Mexico until one day when Shiprock, a Navajo Shrine, could not be seen 20 miles upward from the plume. At that time, the fragile and transitory nature of the environment was recognized. No-significant deterioriation is important not only to insure preservation of a precious environmental heritage, but to provide a tool to promote full economic development in a rational way, according to Clayton.

The concern about visibility is not isolated from other issues. The same pollutants that reduce visibility can have significant impact on crop production. A study by the National Academy of Sciences suggests that a doubling of present pollution levels on the east coast could, under otherwise

favorable conditions, produce a 25 to 100% loss of many agronomic and horticultural crops and cause severe injury to many natural species. The Administrator of the Department of Agriculture's Agricultural Research Service has testified repeatedly that air pollutants are responsible for reductions in yield and quality of crops. Yield reductions in some locations range from 25 to 75%.

Major policy questions evolving from this controversy include the following:

(1) Should an explicit definition of "significant deterioration" be included in the Act to express the intent of Congress?

(2) In view of the strong implications of preventing significant deterioration on some land use decisions, should Congress grant greater flexibility to EPA, States, or local jurisdictions to determine their "clean air areas"? If so, should flexibility be in the form of EPA power to grant variances or should it be in the form of State and local control over "their own destiny"?

(3) Should a no-significant deterioration policy be enlarged to encompass mobile sources of pollution?

(4) Should the policy include all pollutants regulated under the Act?

(5) In view of the dependence on a clean environment of some economic activities such as agriculture and tourism, should the ambient air be allowed to deteriorate?

(6) Should there be an evaluation of planned activities, including a benefit-cost analysis of all impacts such as air quality? If so, should local or national benefit be the decisive factor?

LEGISLATION

A most comprehensive congressional overview of the Clean Air Act is underway. The two clean bills submitted for floor action in the House and the Senate are:

H.R. 10498 (Rogers et al.)

Clean Air Act Amendments. Section 108 is directed at several purposes: (1) to protect health from harmful exposures occurring at levels below the ambient standards; (2) to protect national parks and other areas of special natural, recreational, scenic, or historic value; (3) to prevent competition for industry among States to be waged by allowing significant deterioriation of air quality; (4) to prevent interstate air pollution which significantly degrades air quality; and (5) to assure careful evaluation of all consequences and opportunity for full public participation prior to a State's decision allowing deterioration in existing clean air areas. It retains the three area classification systems existing in the current regulations. Class I is mandatory for national parks and national wilderness areas exceeding 25,000 acres. Smaller areas exceeding 10,000 acres would be Discretionary Class I. The Discretionary areas could be reclassified to Class II at the discretion of the State. Any reclassification of Federal land is subject to State and local approval and reclassification must not interfere with the classification of other areas.

The following limitations would apply:

Allowable Pollution Increments

Class I
--2% of lowest national standard
(all pollutants except particulate)
--10% of lowest national standard
(all pollutants)

Class II
--25% of lowest national standard
(all pollutants)

Class III
--50% of lowest national standard

Allowable Pollution Ceilings

Classes I, II, and III
--90% of primary air quality
standard (all pollutants), or the
levels permitted under secondary
standards, whichever is lower.

Only new and modified sources emitting 100 tons of pollutants annually would be required to obtain preconstruction permits.

H.R. 10498 was reported to the House from the Committee on Interstate and Foreign Commerce, with an amendment, on May 15, 1976 (H.Rept. 94-1175). Floor debate started Aug. 4, 1976.

S. 3219 (Muskie)

Amends the Clean Air Act to establish procedures for the prevention of significant deterioration of air quality by regulating the construction and location of new emission sources. New subsec. 110(g) places primary authority with the States to regulate new major emitting facilities; requires use of best available technology to minimize emissions, a margin of safety to protect ambient air quality standards, two instead of three land classifications to protect areas cleaner than present primary or secondary standards, and elimination of "buffer zones" around areas subject to classification. Requires Federal Government to back State decisions and to protect air quality values of certain Federal lands. Specifies that the national standard to prevent significant deterioration is a single set of increments applicable to all nondeterioration areas, taken from EPA regulations covering the agency's so-called Class II areas.

The allowable increments in pollutant concentration for Class II areas (in micrograms per cubic centimeter) are as follows:

Pollutant
(in micrograms per cubic meter)

Particulate Matter
Annual geometric mean.....10

24-hour maximum.....30

Sulfur Dioxide
Annual arithmetic mean.....15
24-hour maximum.....100
3-hour maximum.....700

However, if a Federal Land Manager files notice alleging that emissions from proposed major emitting facilities may cause or contribute to change in air quality, and he demonstrates to the satisfaction of the State that such emissions would adversely impact on air-quality-related values of such lands, smaller increments will apply.

Allowable increments in Class I areas are as follows:

Pollutant
(in micrograms per cubic meter)

Particulate Matter
Annual geometric mean.....5
24-hour maximum.....10

Sulfur Dioxide
Annual arithmetic mean.....2
24-hour maximum.....5
3-hour maximum.....25

Other pollutants subject to regulation and not covered above would be subject to an EPA study. An EPA report to the Congress within one year will recommend increments for nitrogen oxides and hydrocarbons applicable to stationary source emissions in Class I and Class II areas.

S. 3219 was reported to the Senate (S. Rept. 94-717) on Mar. 29, 1976. During floor debate, the Senate adopted an amendment (No. 1798) by Sen. Randolph to have the National Commission on Air Quality conduct a two-year study of nondegradation policy. Amendment (No. 2101) by Sen. Allen enacting, but suspending the effect of, nondegradation provisions of S. 3219, leaving EPA regulations in place for one year following completion the Commission study, was defeated. Also defeated was an amendment (No. 290) by Sen. Moss which called for deletion of the bill's nondegradation language pending a one-year study of the issue, as was an amendment (No. 291) by Sen. William Scott which would have deleted all nondegradation regulations during the one-year study period. Also rejected was an amendment (No. 1610) by Sen. Gary Hart that would have modified the definition of nondegradation "increments" to include emissions from all sources, but only major polluters, and an amendment (No. 1644) by Sen. Hatfield to classify as mandatory Class I national monuments in excess of 10,000 acres and managed by the National Park Service. The Senate approved an amendment (No. 301) by Sen. Ted Stevens which requires Congress to designate new national parks or wilderness areas either Class I or II, and an amendment (No. 2089) by Sen. Bumpers which increases from 5,000 to 6,000 acres the minimum size of national parks required to be designated Class I. Finally, an amendment (No. 2115) by Sen. William Scott to kill the nondegradation provisions, was also rejected. The Senate passed S. 3219 with amendments, on Aug. 5, 1976.

While prevention of significant degradation was being debated in Congress, the U.S. Court of Appeals for the District of Columbia on Aug. 4,

1976, upheld EPA's current nondegradation provisions against challenges from several States, industry, and environmental groups. The court stated that it found no substantial reason to question the continued validity of the Sierra Club v. Ruckelshaus decision pursuant to which EPA's regulations had been promulgated, and that it considered the regulations rational and in accordance with the law.

HEARINGS

U.S. Congress. House. Committee on Interstate and Foreign Commerce. Subcommittee on Public Health and Welfare. Air pollution control and solid waste recycling. Hearings, 91st Congress, 1st and 2d session. Parts 1 and 2. Washington, U.S. Govt. Print. Off., 1969, 1970. 891 p.
Hearings held Dec. 8 and 9, 1969; Mar. 5, 16-20; Apr. 14, 1970.

U.S. Congress. House. Committee on Interstate and Foreign Commerce. Subcommittee on Public Health and Environment. Clean Air Act Amendments--1975. Hearings, 94th Congress, 1st session, on titles V and VI of H.R. 2633 and H.R. 2650 (and all other bills which amend the Clean Air Act). Part 1. Washington, U.S. Govt. Print. Off., 1975. 1308 p.
Hearings held Mar. 13-14, 17-20, 26, 1975.
"Serial no. 94-25"

----- Clean Air Act Oversight-1973. Hearings, 93d Congress, 1st session, on a review of the implementation of various provisions of the Clean Air Act of 1970. Sept. 10-21, 1973. Part 1. Washington, U.S. Govt. Print. Off., 1973. 1077 p.
"Serial no. 93-62"

U.S. Congress. Senate. Committee on Public Works. Subcommittee on Environmental Pollution. Clean Air Act Oversight. Hearings, 93d Congress, 2d session. May 13-16, 20-22; and June 3, 1974. Washington, U.S. Govt. Print. Off., 1974. 1522 pp.
"Serial no. 93-H42"

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Hearings, held Feb. 16-18, 23-25; Mar. 2, 27, 28; Apr. 10, 11; May 22, 1972, Washington, D.C. Mar. 25, 1972, Los Angeles, Calif.

----- Nondegradation policy of the Clean Air Act. Hearing, 93d Congress, 1st session. July 24, 1973. Washington, U.S. Govt. Print. Off., 1972. 417 p.

U.S. Congress. Senate. Committee on Public Works. Subcommittee on Environmental Pollution. Implementation of the Clean Air Act, 1975. Hearings, 94th Congress, 1st session. Mar. 19, 20; Apr. 21, 23, 1975. Washington, U.S. Govt. Print. Off., 1975.
"Serial no. 94-H-10"

REPORTS AND CONGRESSIONAL DOCUMENTS

U.S. Congress. House. Committee on Interstate and Foreign Commerce. Clean Air Act Amendments of 1976; report to accompany H.R. 10498 together with additional, separate, opposing, and minority views. May 15, 1976. Washington, U.S. Govt. Print. Off., 1976. 507 p. (94th Congress, 2d session. House. Report no. 94-1175)

----- Clean Air Act Amendments of 1976; supplemental report to accompany H.R. 10498 together with additional views [including cost estimate of the Congressional Budget Office]. May 25, 1976. Washington, U.S. Govt. Print. Off., 1976. 10 p. (94th Congress, 2d session. House. Report no. 94-1175, Part 2)

----- Clean Air Act Amendments of 1976, summary of the bill (H.R. 10498); staff report. Washington, U.S. Govt. Print. Off., May 1976. 25 p.
At head of title: 94th Congress, 2d session. Committee print. no. 21.

U.S. Congress. Senate. Committee on Public Works. Air quality and and stationary source emission control; report by the National Academy of Sciences. Washington, U.S. Govt. Print. Off., March 1975. p. 173-174.
At head of title: 94th Congress, 1st session. Committee print.
"Serial no. 94-4"

----- Clean Air Amendments of 1976; report together with minority and individual views to accompany S. 3219. Washington, U.S. Govt. Print. Off., 1976. 231 p. (94th Congress, 2d session. Senate. Report no. 94-717)

----- National Air Quality Standards Act of 1970. Washington, U.S. Govt. Print. Off., September 1970. 129 p. (91st Congress, 2d session. Senate. Report no. 91-1196)

OTHER CONGRESSIONAL ACTION

N/A

CHRONOLOGY OF EVENTS

08/05/76 -- The Senate passed S. 3219 with amendments.

08/04/76 -- The House began floor debate on H.R. 10498.

08/01/76 -- The U.S. Court of Appeals of D.C. upheld EPA's nondegradation regulations.

05/25/76 -- A supplemental report containing the cost estimate of the Congressional Budget Office was filed by the Committee on Interstate and Foreign Commerce (H.Rept. 94-1175,

Part 2).

05/15/76 -- H.R. 10498 was reported to the House by the Committee on Interstate and Foreign Commerce (H.Rept. 94-1175).

03/29/76 -- S. 3219 was reported to the Senate by the Committee on Public Works (S.Rept. 94-717). The bill contains decisions on revising the Clean Air Act as agreed by the full committee.

10/31/75 -- The Clean Air Act Amendments bill, H.R. 10498, was introduced in the House.

06/12/75 -- EPA amended regulations.

06/09/75 -- EPA amended regulations.

12/05/74 -- EPA published final regulations.

08/27/74 -- EPA issued notice of proposed regulations for prevention of significant air quality deterioration.

10/00/73 -- EPA held public hearings on the four alternative plans in Washington, D.C., Atlanta, Dallas, Denver, and San Francisco.

07/16/73 -- EPA published notice of intent to select one or a combination of four alternative plans to prevent significant deterioration of air quality.

06/11/73 -- U.S. Supreme Court, by an equally divided decision, affirmed the judgment of the Court of Appeals.

11/09/72 -- U.S. Court of Appeals for the District of Columbia Circuit affirmed decision of District Court. In response to Court decrees, EPA disapproved State plans that fail to prevent significant deterioration of air quality.

05/30/72 -- District Court of the District of Columbia held that EPA must disapprove those plans not preventing significant deterioration of air quality, and establish procedures to effectively prevent deterioration.

05/24/72 -- Sierra Club filed suit in District Court seeking a declaratory judgement and injunction requiring EPA to disapprove State implementation plans that do not contain procedures for preventing significant deterioration of air quality.

02/16/72 -- Natural Resources Defense Council testified, and was critical of EPA regulations including absence of nondegradation concept.

01/30/72 -- Each State required to adopt and submit a State implementation plan to EPA.

08/14/71 -- EPA published guidelines to assist States in developing, adapting, and submitting plans to implement the ambient air standards.

04/27/71 -- EPA promulgated national ambient air standards.

01/27/71 -- EPA proposed national ambient air standards.

12/31/70 -- Clean Air Act, P.L. 91-604, enacted.

ADDITIONAL REFERENCE SOURCES

Amici Curiae Briefs prepared for the Supreme Court deliberation on Ruckelshaus v. Sierra Club.

Environmental Protection Agency. Technical Support Document -- EPA regulations for preventing the significant deterioration of air quality. Washington (EPA-450/2-75-001) January 1975. 115 p.

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EPA reviews clean-air areas at hearings. Electric world. Oct. 1, 1973.

Farrell, Barbara B. The nondegradation controversy: How clean will our "clean air" be? University of Illinois law forum, v. 1974, no. 2. 1974: 314-340.

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----- 39FR3100. Aug. 24, 1974.
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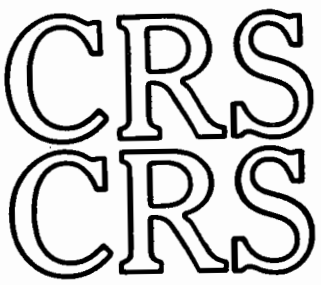
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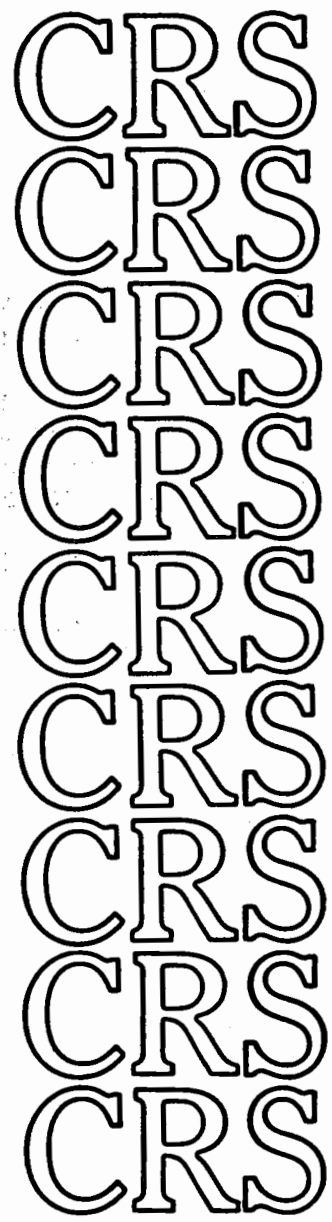
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National Research Council, National Academy of Sciences. Genetic vulnerability of major crops [by] Committee on Genetic Vulnerability of Major Crops, Agricultural Board, Division of Biology and Agriculture. Washington, D.C., 1972. 307 p.





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ISSUE DEFINITION

The Community Mental Health Centers (CMHC) Act, as amended, provided project grants for the construction, initial staffing, and support of special services in community-based mental health center programs. Authorizing legislation expired on June 30, 1974, and the program was extended through a series of continuing resolutions. The 93rd Congress passed legislation that would have extended and amended the program (H.R. 14214), but the bill was vetoed by President Ford. Similar legislation was passed by the 94th Congress over a Presidential veto on July 29, 1975, extending the CMHC Act through FY 1977. The FY 1976 budget proposes a gradual elimination of Federal support for Community Mental Health Centers--no new centers would be funded; existing commitments would be honored for the duration of the 8-year period only. The extent to which the new CMHC legislation can be implemented will depend on the appropriation levels approved for FY 1976 and future years.

BACKGROUND AND POLICY ANALYSIS

Congress created the Community Mental Health Centers (CMHC) program in 1963. The passage of the Act was prompted by the Report of the Joint Commission on Mental Illness and Health, which publicized the extent of mental illness (currently 20 million people in the United States suffer from some form of mental or emotional illness) and the need for alternative treatment facilities. In 1965, Congress expanded the scope of the original Act to include a program of short-term grants to help meet the costs of initially staffing community mental health centers.

The purposes of the CMHC Act were broadened in 1968 to include new programs of construction and staffing assistance for centers and other specialized facilities involved in the treatment of alcoholism and drug addiction.

Major amendments to the basic legislation were made again in 1970. The maximum Federal share of support for construction projects, 66-2/3%, was increased to 90% in those areas designated as poverty areas. The duration of the staffing grant was extended from 51 months to 8 years, beginning at a matching rate of 75% for a 2-year period, decreasing annually to 60%, 45%, and then to 30% for the last 4 years. Poverty areas were made eligible for higher levels of staffing support: 90% for 2 years, 80% for the third year, 75% for the next 2 years, and 70% for the last 3 years.

The 1970 amendments also provided separate funding for mental health services for children. Other additions included: (1) a program of initiation grants for the purpose of assessing local mental health needs, (2) a program of direct grants for special projects relating to alcoholism and drug addiction, and (3) funds for consultation services provided in centers and specialized treatment facilities. These programs were authorized through FY 1973.

Since the FY 1974 budget submission, the Administration has supported a policy of allowing the authority for the Community Mental Health Centers Act to expire and providing funds to finance existing commitments (the 8-year staffing grants) only. The congressional committees with jurisdiction over

the CMHC program have disagreed, and have proposed continued funding and extensions and amendments to the legislation. The major issues involve differences over the original intent of the program and the availability of alternative sources of funding.

Intent of the Program. The Department of Health, Education, and Welfare (HEW) contends that the CMHC program was intended to be a demonstration program. In the justification for the FY 1976 budget, they state that "...the Federal role should be limited to demonstrating the feasibility of service models." The HEW press release accompanying the FY 1976 budget reports that "This community approach to treatment should now be absorbed by the regular health service delivery system..." The congressional committees with jurisdiction over the CMHC program contend that the legislative history of the program supports their view that the intent of the program was a nationwide network of community mental health centers, supported for an initial period of time. The Senate Committee on Labor and Public Welfare sums up this view in its report on S. 66 by stating: "The goal of a nationwide network of community mental health centers--with the Federal Government providing the initial staffing grants--was clearly accepted by the Executive and Legislative Branches of government in 1963, in 1965, in 1967, in 1969, and in 1971." In discussing the intent of Federal support, the report states: "Permanent Federal support--'no.' Federal support for initial 'start-up' costs wherever needed in the U.S.--'yes.'"

Alternative Sources of Funding. In phasing out Federal support for CMHC's, HEW contends that greater reliance will be placed upon alternative sources of funding, such as third-party payments and State and local governments. Congressional committees have disagreed, contending that such funding will not be sufficient, at least until the advent of a comprehensive form of national health insurance. They point out that receipts for services amounted to only 21.1% of funds for CMHC's in 1972, with Medicare reimbursements accounting for 1.7% of funds, Medicaid accounting for 5.7%, and commercial insurance accounting for 7.7%. In addition, State and local governments provided some 40.9% of the funds in 1972; it is questionable whether they can assume any larger burden at present. An excerpt from the report of the Senate Committee on Labor and Public Welfare on S. 66 summarizes the views of those advocating continued support:

> "The fact of the matter is that there is no viable alternative at the present time to continued Federal grant support for community mental health centers. "The problem is partly a question of timing. Our Nation is moving toward expanded insurance coverages for mental health services that will ultimately allow CMHCs to become self-sufficient. The Committee believes it would be shortsighted and irresponsible to terminate Federal support for CMHCs and thereby both jeopardize the continued operation of existing centers and eliminate center expansion, particularly at a time when a program of national health insurance is being actively considered for enactment in the Congress."

LEGISLATION

- P.L. 94-63 (S. 66/H.R. 4925)
- Similar to H.R. 14214, 93d Congress, which was vetoed by the President.

Includes sections to amend and extend the CMHC Act through FY77. S. 66 was approved by Congress on July 16, 1975, with authorization levels approximately $500 million less than the separate health services and nurse training bills passed by Congress in late 1974. The President vetoed S. 66 on July 26, 1975, objecting to authorization levels in excess of the Administration's requests for these programs and the categorical nature of the legislation. The veto was overridden in the Senate on July 26 by a vote of 67 to 15; the House overrode the veto 384 to 43 on July 29, 1975. The Community Mental Health Centers Amendments of 1975 were enacted into law as title III of P.L. 94-63.

o The new CMHC legislation (1) provides a definition of a community mental health center; (2) consolidates all of the previously passed requirements for services which a center must provide: inpatient, outpatient, partial hospitalization, emergency, consultation and education, services to children, alcoholics, and drug abusers; (3) adds new provisions for services to the elderly, halfway-house services for those discharged from mental institutions, screening services for referrals to, and follow-up services for those discharged from, State mental institutions; and (4) in addition to the former Federal grants for construction, grants are authorized for planning of centers, operating costs of centers (replacing grants for staffing costs), financial distress grants to centers which have reached the end of their Federal grant without having found alternative sources of support, and grants for consultation and education services to the community.

o P.L. 94-157 (H.R. 10647)

o Supplemental Appropriations Act for FY76. Maintaining their position on the phase-out of the CMHC program, the Administration did not request supplemental funding for FY76 to implement the provisions of the CMHC legislation. Congress responded by passing H.R. 10647 on Dec. 15, 1975, which among other items provides $53.5 million for new CMHC grants in FY76. The bill was signed into law as P.L. 94-157 on Dec. 18, 1975.

o P.L. 94-206 (H.R. 8069)

o Appropriations Act for FY76. On Jan. 28, 1976, Congress passed, over a Presidential veto, an appropriation bill for the Departments of Labor and Health, Education and Welfare, which included $162,207,000 for the continuation of existing grants to Community Mental Health Centers.

o H.R. 14232 (Flood)

o Appropriations for FY77. The President's budget request for Community Mental Health Centers in FY77 was for $130,800,000 to continue existing centers. It also proposed that the Community Mental Health Center program be consolidated, along with 15 other health programs, into one health block grant to the States (see Health Block Grant Consolidation Proposal). No legislative action has been taken on this proposal.

o The House passed H.R. 14232, an HEW appropriations bill for FY77 that includes $235,346,000 for Community Mental Health Centers, on June 24, 1976. The Senate passed an amended bill, including $230,346,000 for CMHCs, on June 30, 1976. Conference is presently being held to resolve differences.

HEARINGS

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---- Health Programs Extension Act of 1973. Hearings, 93d Congress, 1st session, on H.R. 5608 and S. 1136 (and all identical bills). Washington, U.S. Govt. Print. Off., 1973. 601 p.
Hearings held Mar. 27, 28, and 29, 1973.

U.S. Congress. Senate. Committee on Labor and Public Welfare. Public Health Service Act Extension, 1973. Hearing, 93d Congress, 1st session, on S. 1136. Washington, U.S. Govt. Print. Off., 1973. 255 p.
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U.S. Congress. House. Committee on Interstate and Foreign Commerce. Health Revenue Sharing and Health Services Act of 1975; report together with separate, additional, and minority views to accompany H.R. 4925. Washington, U.S. Govt. Print. Off., 1975. 251 p. (94th Congress, 1st session. House. Report no. 94-192)

----- Health Revenue Sharing and Health Services Act of 1974; report together with minority and additional views to accompany H.R. 14214. [Washington, U.S. Govt. Print. Off.] 1974. 170 p. (93d Congress, 2d session. House. Report no. 93-1161)

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U.S. Congress. Senate. Committee on Appropriations. Departments of

Labor and Health, Education, and Welfare and related agencies appropriations bill, 1974; report to accompany H.R. 8877. [Washington, U.S. Govt. Print. Off.] 1973. 137 p. (93d Congress, 1st session. Senate. Report no. 93-414)

U.S. Congress. Senate. Committee on Labor and Public Welfare. Health Facilities, Manpower, and Community Mental Health Centers Act of 1972; report together with individual views to accompany S. 3716. [Washington, U.S. Govt. Print. Off.] 1972. 97 p. (92d Congress, 2d session. Senate. Report no. 92-1064)

----- Health Services Act of 1974; report to accompany S. 3280. [Washington, U.S. Govt. Print. Off.] 1974. 186 p. (93d Congress, 2d session. Senate. Report no. 93-1137)

----- Nurse Training and Health Revenue Sharing and Health Services Act of 1975; report to accompany S. 66. [Washington, U.S. Govt. Print. Off.] 1975. 307 p. (94th Congress, 1st session. Senate. Report no. 94-29)

U.S. Congress. Senate. Committee on Labor and Public Welfare. Subcommittee on Health. Community Mental Health Centers Act; history of the program and current problems and issues. Washington, U.S. Govt. Print. Off., 1973. 19 p.
At head of title: 93d Congress, 1st session. Committee print.

OTHER CONGRESSIONAL ACTION

N/A

CHRONOLOGY OF EVENTS

N/A

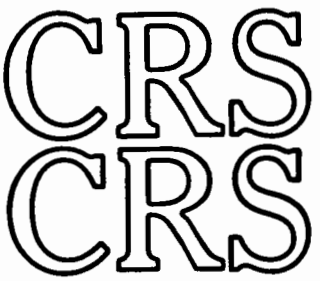
ADDITIONAL REFERENCE SOURCES

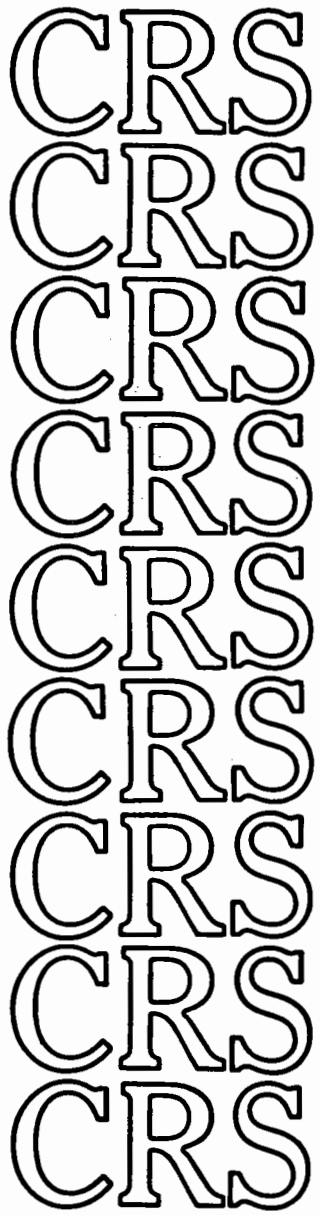
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ISSUE DEFINITION

Aging is a common biological condition that every person experiences. There has been a lack of in-depth research and training concerning the aging process, diseases of old age, as well as physical and mental problems that may occur solely as the result of aging. Because of the necessity for more research into the processes of aging, the concern of interested legislators has been stimulated.

BACKGROUND AND POLICY ANALYSIS

The rate of aging population in the United States is growing more rapidly than the rate of population as a whole. It is estimated that by the year 2000, persons 65 years of age and over will fall in the range of 11 and 16% of the population, or approximately 28 million persons, depending upon the birth rate in the United States over the next three decades. In 1900, the average lifespan for an individual in this country was 49 years. Today, because of the control of diseases from infancy to adulthood, it has advanced to 71 years. The ratio of older women to older men is continuously growing and soon will be much higher than the present 139 to 100. Because of the increase in the number of older Americans, the need for legislation was recognized. Mainly, this interest stemmed from the lack of emphasis that had been placed upon research as regards the aging process as it related to the biomedical, social, and behavioral aspects of aging.

During the 1961 White House Conference on Aging, the establishment of a National Institute on Aging was recommended. Thus, the responsibility of aging research was given to the National Institute of Child Health and Human Development (NICHD), which was created in 1962. Since 1964, only 11% of the budget at NICHD has been alloted to research on aging, 58% has been used for child health, and 31% for population research. The 1971 White House Conference on Aging again urged the organization of a separate institute for aging, because it was found that the NICHD program was inadequate.

During the 92d Congress, hearings were held by the Subcommittee on Public Health and Environment concerning legislation for such an institute. The legislation was passed, but pocket vetoed by the President at the close of the 92d Congress. The President's objection was to the "establishment of a new institute and to a program contained in the legislation of grants to community mental health centers for mental health services for the aged." In the course of the 93d Congress, S. 775 and H.R. 6175 (similar bills to the previous legislation) were introduced. Because of the earlier objections, a provision for a program of mental health service grants for the aged was not included. S. 775 was approved by the Senate in July, 1973 and passed by the House, in lieu of H.R. 6175, on May 2, 1974. The President signed it into law (Public Law 93-296) on May 31.

Under the specifications of the law, the Secretary of Health, Education, and Welfare was directed to: (1) "conduct scientific studies, through the Institute, for the purpose of measuring the impact on the biological, medical, and psychological aspects of aging; (2) carry out public information and education programs to disseminate the findings of the Institute and other relevant information to assist all Americans in understanding the processes of aging; and (3) prepare a comprehensive aging research plan within one year

after enactment for presentation to Congress and the President, along with a statement of the staffing and funding requirements necessary to implement the plan."

The tranfer of aging research activities from the NICHD to the National Institute on Aging (NIA) has been smoothly accomplished.

It has been reported that the primary research continues to gain knowledge as to why the functional capacities of various bodily systems decreases with age. In the clinical research area, researchers have found that the use of the biofeedback technique "operant conditioning" is very useful because the elderly can be taught to slow their heart beat, lower their blood pressure, and control bowel function.

The NIA is the smallest within the National Institutes of Health. It has proposed a budget of $26.2 million for FY77. Because the Institute is new, program definitions have not been made as regards the division of the funding. Dr. Robert M. Butler, a psychiatrist, has been chosen as the director of the Institute, effective May 1976.

LEGISLATION

The 93d Congress enacted S. 775 (in lieu of H.R. 6175) into P.L. 93-296 on May 31, 1974. This law proposed the establishment of an Institute for investigation of medical, psychological, sociological aspects of aging and other problems affecting older persons. It also specified that a National Advisory Council on Aging be organized by the Secretary of Health, Education, and Welfare. The council makes recommendations to the Secretary concerning programs for the aged and matters that relate to the Institute.

94th Congress

o H.R. 1171 (Wilson of Calif.)

o Requires the Secretary of Health, Education, and Welfare to establish in the Public Health Service the National Institute of Aging for the purpose of carrying out research, investigations, experiments, demonstrations, and studies related to the diseases and the special health problems and requirements of the aged. Referred to the Committee on Interstate and Foreign Commerce.

HEARINGS

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Cranston, Alan. Congress responds to recommendation of White House conference on aging--research on aging act of 1973--S. 775. Remarks in the Senate. Congressional record (daily ed.) July 11, 1973: S13063-S13064.

Eagleton, Thomas F. S. 775, a bill to amend the Public Health Service Act to provide for the establishment of a National Institute on Aging. Remarks in the Senate. Congressional record (daily ed.) Feb. 6, 1973: S2124-S2125.

U.S. Congress. Committee on Interstate and Foreign Commerce. Research on aging act of 1974; report to accompany H.R. 6175. Washington, U.S. Govt. Print. Off., 1974. 10 p. (93d Congress, 2d session. House. Report no. 93-906)

OTHER CONGRESSIONAL ACTION

N/A

CHRONOLOGY OF EVENTS

05/00/76 -- Dr. Robert M. Butler became the director of the Institute on Aging.

01/00/76 -- The Institute proposed a budget of $26.2 million for FY77.

01/00/76 -- The deadline for submitting the research plan to the Secretary of HEW has been extended from Mar. 1 to May 31, 1976 because of a lack of funds and personnel.

11/00/75 -- Dr. Robert M. Butler, a psychiatrist in the Washington, D.C. area, is the director designate of the Institute. He is scheduled to begin his directorship in April 1976.

11/00/75 -- The research plan for the Institute is now in its final draft stages. The written plan is expected to be submitted to the DHEW Secretary by Mar. 1, 1976.

07/11/75 -- Dr. Richard Greulich was appointed acting director of the Institute to serve until a permanent director is chosen. He is also one of the candidates being considered for the directorship.

06/09/75 -- The National Advisory Council on Aging met to discuss the research plan for the institute, and also to consider grant applications.

04/24/75 -- The National Advisory Council on Aging held its first meeting to discuss the research plan for the institute.

08/01/74 -- Hearings were held by the Senate Special Committee on Aging

to discuss Public Law 93-296.

06/00/74 -- House approved the transference of $15.5 million from the National Institute of Child Health and Human Development and the Aging Administration budget to the National Institute on Aging.

05/31/74 -- President signed S. 775 into Public Law 93-296 for the establishment of a National Institute on Aging.

03/00/73 -- Hearings were held on S. 775 by the Senate Labor and Public Welfare Committee and the House Interstate and Foreign Commerce Committee.

02/00/73 -- S. 775 introduced in the Senate.

10/00/72 -- President pocket vetoed H.R. 14424, for the establishment of a National Institute on Aging.

04/00/72 -- H.R. 14424 introduced in the House.

03/00/72 -- Senate Labor and Public Welfare Committee held hearings on S. 887, S. 1925, and S. 2934 concerning the organization of a National Institute of Gerontology and to promote advanced research in aging through a comprehensive program for the study of the process of aging in human beings.

12/00/71 -- White House Conference on Aging recommended the "immediate establishment of a national institute to support and conduct research and training in the biomedical and social-behavioral aspects of aging."

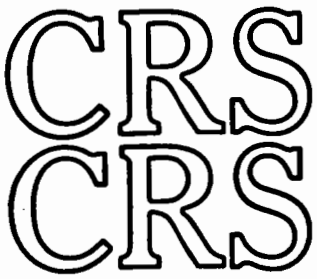
02/00/71 -- S. 887 introduced in the Senate.

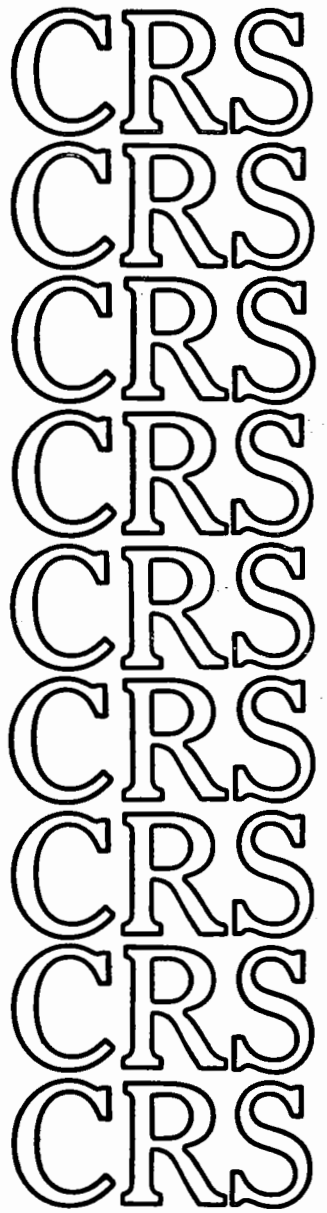
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----- The support of health-related research on aging. Report of the Adult Development and Aging Branch, National Institute of Child Health and Human Development, Bethesda, Md., November 1973. 81 p.





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ISSUE DEFINITION

Child nutrition programs have been developed under Federal auspices to "safeguard the health and well-being of the Nation's children and to encourage the domestic consumption of nutritious agricultural commodities and other foods". Federal cash and donated food assistance are provided to nonprofit public and private schools and child care institutions through various programs. The Administration in its budget for 1977 proposed eliminating the current child nutrition programs and substituting a block grant program instead. H.R. 13208 has been introduced to this effect. Major legislation passed in the 1st session of the 94th Congress not only extended the terminating programs but expanded the continuing programs as well.

BACKGROUND AND POLICY ANALYSIS

As early as 1932, some school lunch programs received Federal loans and agricultural surpluses. In 1935, an amendment to the Agricultural Adjustment Act of 1933 provided funds equal to 30% of gross receipts from customs to act as a farm price support program with special emphasis on certain commodities. The Department of Agriculture, under this authority (Section 32), initiated a direct purchase and distribution program which donated surplus farm commodities to school lunch programs in an effort to dispose of these goods. From 1943 to 1946, the USDA utilized permanently appropriated Section 32 funds to make cash grants to schools to enable them to purchase food locally. In 1946, the school lunch program was permanently authorized in the National School Lunch Act (P.L. 79-396).

The child nutrition programs are nationally administered by the Food and Nutrition Service of the Department of Agriculture in cooperation with State Departments of Education; the special supplemental food program for women, infants, and small children is administered through State Departments of Health. The State, in turn, is responsible for the administration of the local programs. Direct Federal administration is given in private schools where the State educational agency is prohibited from disbursing funds and in child care institutions where no State agency is responsible for the administration. The Food and Nutrition Service has direct responsibility for funding feeding programs in all Head Start programs.

National School Lunch Act, As Amended

The school lunch program was established in 1946 to "provide assistance to the States in the establishment, maintenance, operation, and expansion of school lunch programs." Since that time, the Act has been amended to incorporate other programs and increase the amount of Federal assistance.

Section 4 (General Assistance) of the Act guarantees Federal subsidies of at least 10 cents for each type A lunch served. (Type A lunches consist of groupings of food that have been determined to meet the nutritional needs of children aged 10-12.) A semi-annual adjustment in the rate is provided, based on changes in the cost-of-food-away-from-home series of the Consumer Price Index. As of July 1976, the rate is 13.0 cents per lunch served. In addition to Section 4 money, Special Assistance for free and reduced-price

lunches to needy children is guaranteed under the authorization of Section 11. These reimbursements, legislatively set at a minimum of 45 cents for free lunches and 10 cents less for reduced-price lunches, have now risen to 58.50 cents and 48.50 cents respectively--in addition to the 13.0 cents currently provided under Section 4. These rates are also subject to semi-annual adjustment. A child whose family income is under the Secretary's poverty guideline is automatically eligible for a free lunch. Presently, this level is $5,010 for a family of four; this guideline is adjusted annually. The State has the discretion to serve a free lunch to a child whose family income is no more than 125% of the level and a reduced-price lunch to a child whose family income is no more than 195% of the poverty guideline.

The Summer Food Service Program for Children, originally authorized in 1968 by P.L. 90-302 as part of the Special Food Service Program for Children, has been expanded by P.L. 94-105. This program provides food service to children who participate in a nonresidential public or private, nonprofit institution, or residential public or private nonprofit summer camp which develops special summer programs to provide food service similar to the school lunch and school breakfast programs. The children must be from areas in which at least 33-1/3% of the children are eligible for a free or reduced-price meal under the National School Lunch Act.

The Child Care Food Program newly created by P.L. 94-105 was also originally part of the Special Food Service Program for Children. This program provides meals for children in institutions which are nonresidential public or private nonprofit organizations such as day care centers, settlement houses, recreation centers, family day care programs, Head Start centers, Homestart programs, and institutions providing day care services for handicapped children. Reimbursement rates and commodity donation rates are the same as those in the school lunch and breakfast programs, with reimbursement for supplements being 16.0 cents for a free supplement, 10.75 cents for a reduced-price supplement in addition to the general assistance of 5.25 cents.

The Special Supplemental Feeding Program for Women, Infants, and Children (WIC), authorized in 1972, provides nutritious supplemental food for nutritionally deficient and low-income pregnant and lactating women, and to infants and children up to 5 years of age. Cash grants are given to State health departments or comparable agencies in order to purchase the necessary food or provide vouchers for this food for eligible participants.

Federally purchased surplus and price-support commodities and certain other foods are donated to schools participating in the child nutrition program. Presently, the minimum level for federally donated commodities or "cash in lieu of commodities" is 11.75 cents per meal. This level is updated annually according to food price changes. The Department of Agriculture is mandated to grant "cash in lieu of commodities" to States during any fiscal year that the Department has not been able to provide at least 90% of the commodity assistance it had promised to the schools.

Funds are available for nutritional surveys, evaluation, and training services to supplement the nutritional benefits of the child nutrition programs. Up to 1% of all funds available, excluding the Special Milk Program, may be used for the nutritional training and education of workers, cooperators, and participants of the feeding programs. Necessary surveys and studies of requirements for feeding programs may also be made.

Child Nutrition Act, As Amended

The Child Nutrition Act of 1966 (P.L. 89-642) provided for increased Federal assistance for the strengthening and expansion of food service programs for children. The Special Milk Program, first established in 1954 and made permanent in 1970, was designed to increase the consumption of fluid milk by children. The program is available to all nonprofit public and private schools and child care institutions requesting it. Participating institutions receive a minimum subsidy of 5 cents per half-pint of milk served. This rate is subject to an annual adjustment to reflect increased costs. It is now 6.0 cents. In addition, children who qualify for free lunches are also eligible for free milk.

The Act also authorized the School Breakfast Program which provides reimbursements for the costs of processing, distributing, transporting, sorting, and handling such goods. Federal subsidies are based on guaranteed "performance funding" of at least 8 cents for each breakfast served, and additional guarantees of at least 20 cents for each free breakfast and 15 cents for each reduced-price breakfast served. These rates are updated semi-annually and are now 10.5 cents for each breakfast served, plus either 26.00 cents for each free breakfast or 19.5 cents for each reduced-price breakfast served. Eligibility for reduced-price and free breakfasts is the same as in the lunch program.

The nonfood (equipment) assistance program was formulated to make funds available to States in order to enable schools in low-income areas to purchase food service equipment, other than land or buildings. Through FY 1977, 33-1/3% of the appropriated funds are reserved for those schools having no food service or those schools without the facilites to prepare or receive hot meals.

Funds are also available for State Administrative Expenses for child feeding programs. This money may be used by the State agency for the supervision and provision of technical assistance to the local school districts and service institutions in the management of their food service programs.

In the last decade, Federal expenditures for the school lunch program have increased from less than $75 million to over $2.0 billion for cash and commodities. Almost $900 million is now being spent for programs such as the School Breakfast, Nonschool Food, WIC, and Special Milk, which did not exist then.

Authority) Program Level (Obligations)	1975 (Actual)	1976 (Estimated)	1977 (Budget
		(in thousands)	
School Lunch (Sec. 4)	$ 466.9	$ 521.3	$ 588.0
School Lunch (Sec. 11)	818.4	998.4	1,165.0
School Breakfast	83.0	116.5	184.0
Child Care Food Prog.	47.2	114.0	120.0
Summer Food Prog.	53.6	88.0	132.0
Nonfood Assistance Prog.	28.0	20.7	28.0
Commodities to States	357.6	442.5	586.3
Cash-in-lieu of commodities	5.1	52.5	---
Special Milk Prog.	124.9	144.0	155.0
State Administrative Expenses	6.0	7.7	13.7
Nutrition Training and Surveys	.9	1.0	.7
Federal Operating Expenses	8.9	11.7	14.4
TOTAL	$2,000.5	$2,518.3	$ 2,987.1
Special Supplemental Feeding Program for Women, Infants, and Children (WIC)	$ 92.4	$ 155-170	$290-310

LEGISLATION

P.L. 94-351 (H.R. 14237)

Agriculture and Related Agencies Appropriation Bill, 1977. The bill was signed into law July 12, 1976.

H.Res. 1129 (Whitten)

Disapproves of proposed budget deferral D76-105 of $61 million for the Special Supplemental Food Program (WIC). The House agreed to H.Res. 1129 on Apr. 12, 1976.

P.L. 94-105 (H.R. 4222)

National School Lunch Act and Child Nutrition Act of 1966, Amendments of 1975. Makes the School Breakfast Program permanent. The reduced-price lunch program is made mandatory in schools participating in the National School Lunch Program, while eligibility for the program is expanded to 95% above the Agriculture Secretary's poverty guideline. Children of unemployed parents whose income during this period of unemployment meets the income eligibility guidelines shall be immediately eligible for the free and reduced-price lunch program. Children's residential institutions are made eligible for both the school lunch and breakfast programs. The Special Supplemental Food Program for Women, Infants, and Children (WIC) is extended for 3 years, and the eligibility for the program is revised to increase participation. The Summer Food Service Program For Children (originally the Special Food Service Program for Children), which provides meals for needy school children during the summer, is extended for 2 years and includes nonprofit summer camps. A separate section for the Child Care Food Program (formerly the year-round section of the Special Food Service Program) authorizes meals for children in nonresidential institutions providing child care; the program is extended for 3 years. This bill also provides, beginning June 1, 1976, for the use of current data in the issuance of the income poverty guidelines for eligibility in the child feeding programs. The Secretary's special purchasing authority for commodities is extended for 2 years. States which phased out their commodity distribution facilities prior to July 1, 1974, may elect to receive cash in lieu of commodities. This bill also directs the Secretary to include cereal, shortening, and oil in the food donations to the school lunch program. The bill became law on Oct. 7, 1975, after the House and Senate overrode a Presidential veto.

P.L. 94-28 (H.R. 7136)

Continued the special supplemental food program for women, infants, and children through Sept. 30, 1975. The bill was signed into law on May 28, 1975.

P.L. 94-41 (H.J.Res. 499)

Continues the School Breakfast Program until the Agriculture appropriations bill is passed. The joint resolution was signed into law on June 27, 1975.

P.L. 94-20 (S. 1310)

Continued the Special Food Service Program for Children through Sept. 30, 1975. The bill passed the Senate Mar. 26, 1975, was amended and passed in

the House Apr. 9, 1975; the Senate agreed to these amendments on Apr. 18, 1975. The bill was signed into law on May 2, 1975.

S. 894 (Humphrey)/H.R. 2058 (Talcott)

Child Nutrition Act. Provides for the establishment of a universal food service program of at least one free meal per day for children in schools and in service institutions conducting programs for the benefit of all children. Authorizes a voluntary nutrition education program for children through State educational agencies to schools and service institutions. Provides for the creation of a National Advisory Council on Child Nutrition Programs. S. 894 was introduced on Feb. 28, 1975, and was referred to the Senate Committee on Agriculture and Forestry. H.R. 2058 was introduced on Jan. 23, 1975, and was referred to the House Committee on Education and Labor.

S. 1309 (Case)

Amends the Child Nutrition Act of 1966 to restore to the Secretary of Agriculture the authority to regulate the sale of competitive foods in participating schools and institutions. Directs the Secretary to make cash grants to State education departments or comparable agencies for programs to increase the school children's knowledge of the nutritional value of foods and the relationship of nutrition of human health. The bill was introduced on Mar. 24, 1975, and was referred to the Senate Committee on Agriculture and Forestry.

S. 1945 (McGovern)/H.R. 8584 (Miller et al.)

National Nutrition Education Act of 1975. Establishes a system of grants for teacher training, pilot and demonstration projects, and development of comprehensive nutrition education programs for 3 years. The program, which would be administered by the State educational agency through a Nutrition Education Coordinator, would be advised by a State Advisory Council for Nutrition Education. In addition, the bill creates within the Office of Education of the Department of Health, Education, and Welfare, a National Nutrition Education Resource Center. The bill was introduced on June 16, 1975, and was referred to the Senate Committee on Labor and Public Welfare.

S. 2633 (Morgan)

Requires that free lunches be served to all children participating in the school lunch program, and terminates the school breakfast program. The bill was introduced on Nov. 6, 1975, and was referred to the Committee on Agriculture and Forestry.

S. 2488 (Morgan)

Requires that free lunches be served to all children participating in the school lunch program. The bill was introduced on Oct. 7, 1975, and was referred to the Committee on Agriculture and Forestry.

S. 2905 (Hart of Mich.)/H.R. 11967 (O'Hara)

Commodity Supplemental Food Program Act of 1976. Adds a new section to the Child Nutrition Act of 1966 to carry out the supplemental feeding programs (not WIC) through additional funds of up to 20% of each local program's budget to pay administrative and other nonfood costs. Other major provisions are the mandate for specific types and quantities of food, substitutions where shortages of commodities occur, and the allowance of the Commodity Supplemental Food Program in the same geographic area in which a

food stamp program or other food distribution program is in operation provided that recipients do not participate in two programs. The bill was introduced on Jan. 30, 1976 and referred to the Committee on Agriculture and Forestry.

S. 3449 (Humphrey et al.)

National Child Nutrition Information and Education Act of 1976. Authorizes the Secretary of Agriculture to formulate and carry out a program to provide for nutritional training of food service and education personnel and the conduct of nutrition education activities in schools and child care institutions eligible under the National School Lunch and Child Nutrition Acts. Grants to the States are to be based on a rate of 50 cents for each child enrolled in schools or institutions. The bill also establishes a Food and Nutrition Information and Education Resources Center within the National Agricultural Library. S. 3449 was introduced on May 18, 1976, and referred to the Committee on Agriculture and Forestry.

H.R. 12345 (Sisk)

Requires compliance with the Buy American Act in the school lunch program. Referred to the Committee on Education and Labor.

H.R. 13208 (Michel)

Establishes a block grant program that would consolidate all child feeding programs. Each State would be provided Federal funds based upon the proportion of children in the State to the country's total number of needy children. The reimbursement rate for FY77 would be fifty cents for each needy child aged 0 to 4, and ninety-four cents for each needy child aged 5 to 17, multiplied by 225 days. Commodities may be substituted for a portion of the grant, not to exceed 40%. Funds will be provided to the States for administrative expenses. H.R. 13208 was introduced in the House on Apr. 13, 1976, and was referred to the Committee on Education and Labor.

HEARINGS

U.S. Congress. House. Committee on Education and Labor. Subcommittee on Elementary, Secondary, and Vocational Education. The National School Lunch and Child Nutrition Act Amendments of 1975. Hearings, 94th Congress, 1st session, on H.R. 3736. Mar. 4 and 10, 1975. Washington, U.S. Govt. Print. Off., 1975. 192 p.

U.S. Congress. Senate. Committee on Agriculture and Forestry. Subcommittee on National School Lunch and Child Nutrition Act Amendments of 1975. Hearings, 94th Congress, 1st session, on S. 850. Apr. 22 and 24, 1975. Washington, U.S. Govt. Print. Off., 1975. 308 p.

REPORTS AND CONGRESSIONAL DOCUMENTS

U.S. Congress. Conference Committee. National School Lunch Act and Child Nutrition Act of 1966 Amendments of 1975; conference report to accompany H.R. 4222. 35 p. (94th Congress, 1st session. House. Report no. 94-427)

----- National School Lunch Act and Child Nutrition Act of 1966 Amendments of 1975; conference report to accompany H.R. 4222.

35 p. (94th Congress, 1st session. House. Report no. 474)
LRS75-9954

U.S. Congress. Conference Committee. National School Lunch Act and Child Nutrition Act of 1966 Amendments of 1975; conference report to accompany H.R. 4222. 35 p. (94th Congress, 1st session. Senate. Report no. 94-347)

----- National School Lunch Act and Child Nutrition Act of 1966 Amendments of 1975; conference report to accompany H.R. 4222. 35 p. (94th Congress, 1st session. Senate. Report no. 94-379)

U.S. Congress. House. Committee on Education and Labor. National School Lunch Act and Child Nutrition Act of 1966 Amendments of 1975; report together with additional, minority, supplemental and individual views. Washington, U.S. Govt. Print. Off., 1975. 52 p. (94th Congress, 1st session. House. Report no. 94-68)

U.S. Congress. Senate. Committee on Agriculture and Forestry. National School Lunch Act; report to accompany S. 1310. [Washington, U.S. Govt. Print. Off.] Mar. 24, 1975. 5 p. (94th Congress, 1st session. Senate. Report no. 94-57)

----- Special supplemental food program for women, infants, and children; report to accompany S. 1780. [Washington, U.S. Govt. Print. Off.] May 22, 1975. 4 p. (94th Congress, 1st session. Senate. Report no. 94-158)

U.S. Congress. Senate. Committee on Agriculture and Forestry. Subcommittee on Agricultural Research and General Legislation. Comprehensive study of the Child Nutrition Programs--July 1974. Washington, U.S. Govt. Print. Off., Sept. 10, 1974. 87 p.
At head of title: 93d Congress, 2d session. Committee print.

U.S. Congress. Senate. Select Committee on Nutrition and Human Needs. School food program needs--1975 State School Food Service Director's response; a working paper. Washington, U.S. Govt. Print. Off., April 1975. 213 p.
At head of title: 94th Congress, 1st session. Committee print.

----- WIC program survey--1975; a working paper. Washington, U.S. Govt. Print. Off., April 1975. 291 p.
At head of title: 94th Congress, 1st session. Committee print.

U.S. President, 1975- (Ford). Veto of the National School Lunch Act and Child Nutrition Act of 1966 Amendments of 1975. [Washington, U.S. Govt. Print. Off., 1975] 20 p. (94th Congress, 1st session. House. Document no. 94-273)
Message dated Oct. 3, 1975.

CHRONOLOGY OF EVENTS

04/12/76 -- The House agreed to H.Res. 1129.

10/07/75 -- The Presidential veto of H.R. 4222 was overridden in the Senate by a vote of 79 to 13.

-- The Presidential vetc of H.R. 4222 was overridden in the House by a vote cf 397 to 18.

10/03/75 -- H.R. 4222 was vetoed by the President, with a message.

09/19/75 -- H.R. 4222 was passed in the Senate by a voice vote.

09/18/75 -- H.R. 4222 was passed in the House by a vote of 380 to 7.

09/05/75 -- H.R. 4222 was reccmmitted to the Committee on Conference by the Senate (rcllcall vote 76-0).

07/30/75 -- H.R. 4222 was repcrted out of conference by the House and Senate.

07/10/75 -- H.R. 4222 was passed in the Senate by a vote of 81 to 8.

06/27/75 -- H.J.Res. 499 was signed into law (P.L. 94-41) by the President.

05/28/75 -- H.R. 7136 was signed into law (P.L. 94-28) by the President.

05/02/75 -- S. 1310 was signed into law (P.L. 94-20) by the President.

04/29/75 -- H.R. 4222 was referred to the Senate.

04/28/75 -- H.R. 4222 was passed in the House by a vote of 335 to 59.

04/24/75 -- Hearirgs were held cn S. 850 by the Senate Subcommittee cn Agricultural Research and General Legislation of the Ccmmittee on Agriculture and Forestry.

04/18/75 -- The Senate agreed tc House amendments on S. 1310 by a vote cf 82 tc 0.

04/09/75 -- S. 1310 was passed in the House with amendments by a vote cf 396 tc 2.

03/26/75 -- S. 1310 was passed in the Senate.

03/25/75 -- H.R. 4222 was debated in the House and referred back to the Ccmmittee cn Educaticn and Labor.

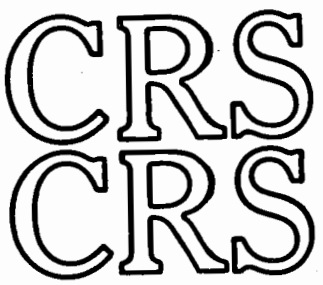
03/24/75 -- Debate was held cr H.R. 4222 in the House.

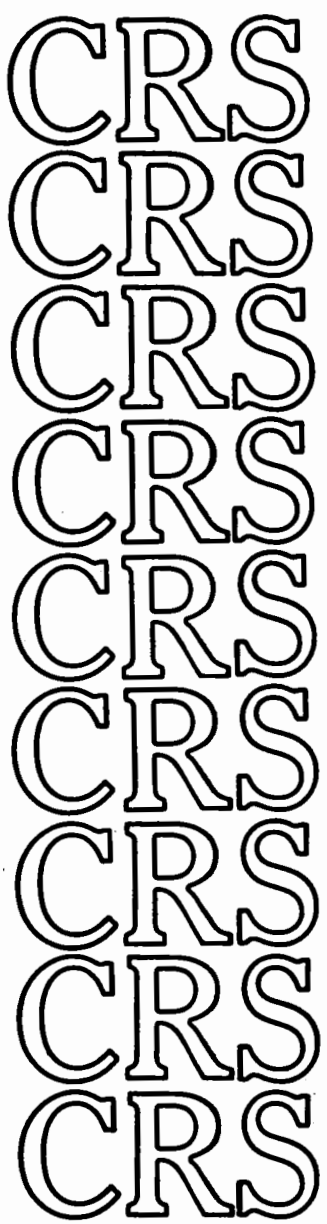
03/17/75 -- H.R. 4222 was reported in the House (94-68).

03/11/75 -- H.R. 4222 was ordered reported as amended by the Ccmmittee cn Education and Iabor.

03/10/75 -- Hearings were held cr H.R. 4222 by the House Subcommittee on Elementary, Secondary, and Vocational Education of the Committee cn Education and Labor.

02/03/75 -- President Ford in his FY 1976 budget proposed elimination cf current child nutrition programs and the substitution of a block grant prcgram.





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Norman Beckman
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MEDICAL CARE PRICES

ISSUE BRIEF NUMBER IB75004

AUTHOR:

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ISSUE-DEFINITION-

The strong inflationary trend that has characterized the American economy recently has been reflected more sharply in the acceleration of medical care prices than in the prices of most other goods and services. Some decline in the rates of acceleration of medical care prices occurred during the 2-1/2 years of the Economic Stabilization (or price control) Program. Since the end of that program in April 1974, medical care prices have again risen dramatically and at a pace more rapid than the prices of most other items in the economy.

Ten years ago, Congress enacted major health care programs for the aged and the poor. A significant rise in the rate of increase in medical care prices followed. Major proposals have been introduced in the 94th Congress to establish a program of national health insurance in which medical care prices and financing are major issues (see IB73015, National Health Insurance).

BACKGROUND-AND-POLICY-ANALYSIS-

Historically, charges for hospital and physician services have always increased more rapidly than prices for consumer goods and services in general. During the 1950s, medical care prices, as measured by the Consumer Price Index (CPI), rose at an average annual rate of 3.9%--nearly twice the 2.1% annual rate reported for all consumer prices. During the first half of the 1960s, there was a perceptible decline in the rates of increase for all consumer prices. All CPI items rose at an average annual rate of 1.3%--about half the rate recorded for the medical care price index (2.5%). This long-term relationship between the two sets of indices (i.e., the all-CPI index and the medical care index) changed during the 1965-1970 period. Prices for goods and services in general rose at an average annual rate of 4.2%, while medical care prices increased at a 6.1% rate.

In August 1971, the President ordered a 90-day freeze on prices, wages, salaries, and rents and the creation of a Cost of Living Council to administer the freeze and to advise on further economic stabilization policies. Three months later, Phase II of the Economic Stabilization Program (ESP) began. The ESP goal was to reduce the rate of inflation to about one-half of the pre-freeze rate. Because of the special problems of inflation in the health care industry, a special advisory panel was established to assist the Council in the health area. In December 1971, specific mandatory Phase II rules were promulgated for the health care industry, rules which were continued for the industry when the Phase III, or voluntary control program, began in January 1973. Modified controls (Phase IV) were imposed on the health industry in June 1973. Price controls over the health industry (and certain other segments of the economy) ended in April 1974. The effects of these controls on medical care prices are shown in the following table:

Annualized Rates Of Increase (%)

Item	Before ESP (FY69-FY71)	During ESP (Aug.71-Apr.74)	After ESP (Apr.74-June 76)	12 mo. ending Apr. 75	14 mo. ending June 76
CPI, all items	5.6	6.4	8.0	10.2	6.2
Medical care, total	6.7	4.3	11.3	13.9	9.2
Medical care services	7.6	4.9	11.9	14.5	9.6
Hospital service charges	N/A	4.6(1)	14.0	16.8	11.7
Physicians' fees	7.4	4.0	12.5	14.0	11.3
Dentists' fees	6.4	4.2	8.8	11.8	6.4
Drugs and prescriptions	1.2	0.7	7.6	9.2	6.2

(1) Annualized rate of change based on percentage change from Jan. 1972 rather than Aug. 1971.

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TOXIC SUBSTANCES CONTROL

ISSUE BRIEF NUMBER IB75051

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ISSUE DEFINITION

Proposals for the regulation of the production and dissemination of toxic substances are directed toward those toxic substances inadequately controlled by existing legislation. A primary emphasis has been placed upon measures to protect human health against unnecessary exposure to toxic metals and synthetic organic chemicals by requiring premarket testing and other clearances for safety, although, as with present air and water quality legislation, measures to protect the environment are included. Proposed toxic substances control legislation again has been introduced in the 94th Congress. Major points of controversy include the requirements for and the cost of premarket screening of toxic substances and the interrelationship of the proposed legislation to existing laws on toxic substances.

BACKGROUND AND POLICY ANALYSIS

In the Forward Plan for Health FY76-80, the Secretary of Health, Education, and Welfare reported estimates that 80-90% of all cancer is environmentally induced. Excluding smoking and other personal factors, the largest portion of this appears to be related to exposure to toxic substances in the work place. A substantial portion occurs as a result of non-occupational exposures. Other evidence is accumulating that shows the toxic substances being produced and disseminated in modern societies produce many other adverse effects, including many poorly defined but potentially serious, subtle and pervasive effects on various plants and animals in the ecosystem--often not detected until long after the damage occurs. For this reason, the Congress has taken a number of actions over the past decade to emphasize the regulation of toxic substances that are having an adverse effect on human health and the environment.

There are a number of laws currently available that provide for the regulation of toxic substances: the Food, Drug, and Cosmetic Act; the Occupational Safety and Health Act; the Consumer Product Safety Act; the Federal Water Pollution Control Act; the Federal Environmental Pesticide Control Act; the Clean Air Act; and the Atomic Energy Act. These all provide some authority for control of toxic substances.

It has been argued, however, that there still exists a significant need for additional legislation that would provide for an assessment of the potential toxicity of substances before production and dissemination. This would prevent the occurrence of adverse health and environmental effects, instead of trying to initiate corrective action after adverse effects have been detected. The proposed toxic substances legislation has emerged as the mechanism for providing the authority to require premarket screening and testing of chemical substances to identify potential hazards before production and distribution occurs.

Although toxic substances legislation was proposed during the 92d and 93d Congresses, no legislation was enacted. Major differences between the bills introduced in those Congresses focused upon the procedures by which premarket testing was required for those substances that were identified as requiring testing, and the impact upon industry of the costs of that testing. Other differences had to do with the inclusion or exclusion of chemicals, produced in very small amounts, from the provisions of the legislation, the way in

LEGISLATION

S. 3149 (Tunney et al.)

Regulates commerce and protects human health and the environment by requiring testing and necessary use restrictions on certain chemical substances. Reported to the Senate on Mar. 16, 1976, from the Committee on Commerce (S.Rept. 94-698). Passed the Senate, amended, 60 to 13, on Mar. 26, 1976. Referred to the House Committee on Interstate and Foreign Commerce on Mar. 29.

H.R. 14032 (Eckhardt)

Regulates interstate commerce to protect health and the environment from hazardous chemical substances. Reported to the House from the Committee on Interstate and Foreign Commerce on July 14, 1976 (H.Rept. 94-1341). Passed the House, amended, 319 to 45, on Aug. 23, 1976. Subsequently, this passage was vacated, and S. 3149 was passed in lieu after being amended to contain the language of the House bill as passed. Referred to joint conference. [SIMILAR BILLS: S. 776 (Tunney et al.), H.R. 7229 (Eckhardt), H.R. 7548 (Brodhead), H.R. 7664 (McCollister), H.R. 10318 (Eckhardt et al.), H.R. 11576 (Eckhardt et al.), H.R. 12336 (McCollister et al.), H.R. 12440 (Quillen).]

HEARINGS

U.S. Congress. House. Committee on Interstate and Foreign Commerce. Subcommittee on Commerce and Finance. Toxic Substances Control Act. Hearings, 92d Congress, 2d session, on H.R. 5276 (and identical bills) and H.R. 10840 (and identical bills). May 18 and 23, 1972. Washington, U.S. Govt. Print. Off., 1972. 199 p.
"Serial no. 92-73"

----- Toxic substances control legislation--1973. Hearings, 93d Congress, 1st session, on H.R. 5087, H.R. 5356, and H.R. 1014. Mar. 15 and 16, 1973. Washington, U.S. Govt. Print. Off., 1973. 386 p.

U.S. Congress. House. Committee on Interstate and Foreign Commerce. Subcommittee on Consumer Protection and Finance. Toxic substances control legislation--1975. Hearings, 94th Congress, 1st session, on H.R. 7229, H.R. 7548, and H.R. 7664. June 16; and July 9-11, 1975. Washington, U.S. Govt. Print. Off., 1975. 482 p.
"Serial no. 94-91."

U.S. Congress. House. Committee on Science and Technology. Subcommittee on the Environment and the Atmosphere. The costs and effects of chronic exposure to low-level pollutants in the environment. Hearings, 94th Congress, 1st session. Washington, U.S. Govt. Print. Off., 1975. 1457 p.
Hearings held Nov. 7, 10-14, and 17, 1975.

U.S. Congress. Senate. Committee on Commerce. Subcommittee on the Environment. Toxic Substances Control Act. Hearings, 94th Congress, 1st session, on S. 776. Mar. 3, 5, 10 and Apr. 15, 1975. Washington, U.S. Govt. Print. Off., 1975. 362 p.

07/09/75 - 07/11/75 -- House hearings continued on H.R. 7229.

07/00/75 -- Publication of National Academy of Sciences--National Research Council report, "Decision Making For Regulating Chemicals In the Environment." A report prepared by the Committee on the Principles of Decision Making for Regulating Chemicals in the Environment.

06/23/75 -- Administrator of EPA forwarded support for and suggestions for changes in S. 776 to Committee on Commerce.

06/16/75 -- House hearings began on H.R. 7229, the Toxic Substances Control Act.

03/03/75 -- Senate hearings began on S. 776, the Toxic Substances Control Act.

04/00/71 -- Council on Environmental Quality published a report, "Toxic Substances," recommending toxic substances control legislation.

ADDITIONAL REFERENCE SOURCES

Crewdson, Prudence. Toxic substances controversy continues. Congressional quarterly, Jan. 3, 1976: 13-17.

Environmental mutagenic hazards. Science, v. 187, no. 4176, Feb. 14, 1975: 503-514.

Labor testifies on toxic substances bill. Chemical and engineering news. Apr. 28, 1975: 17-18.

Lowrance, William W. Of acceptable risk; science and the determination of safety. Los Altos, Calif., William Kaufmann, Inc., 1976.

Magida, Arthur J. Toxic substances debate focuses on notification and testing. National journal. Feb. 14, 1976: 206-207.

National Academy of Sciences, National Academy of Engineering, Environmental Studies Board; and National Research Council, Committee on Toxicology. Principles for evaluating chemicals in the environment. A report of the committee for working conference on principles of protocols for evaluating chemicals in the environment. NAS-NRC, Washington. 1975. 454 p.

National Academy of Sciences, National Research Council. Decision making for regulating chemicals in the environment. A report prepared by the Committee on Principles of Decision Making for Regulating Chemicals in the Environment. NAS-NRC, Washington, July 1975. 423 p.

National Institute for Occupational Safety and Health. Suspected carcinogens: a subfile of the NIOSH Toxic Substances List. Washington, U.S. Govt. Print. Off., June 1975.

National Science Foundation. Science and Technology Policy Office.

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Norman Beckman
Acting Director

HOSPITAL CARE: EXPENDITURES, COSTS, AND UTILIZATION

ISSUE BRIEF NUMBER IB75086

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ISSUE DEFINITION

Preliminary estimates for FY 1975 indicate that national health expenditures in the United States amounted to $118.5 billion, or about 8.3% of the gross national product. Of this amount, $46.6 billion (or about 39% of the total) was expended for hospital care rendered to patients. This is more than twice the expenditures made for any other single category of health care outlays.

Paying for hospital care figures prominently in each of the major national health insurance proposals now under consideration by the Congress. Expenditures for hospital care also account for the largest portion of the public outlays for health already made each year under the Medicare and Medicaid programs. Rapid escalation in the price of hospital care (see IB75004, Medical Care Prices) is also receiving careful scrutiny by congressional committees.

BACKGROUND AND POLICY ANALYSIS

Hospital Expenditures

Total expenditures for hospital care in the United States have risen annually at "double-digit" rates for nearly an entire decade. During FY 1965 (the year prior to the commencement of the Medicare program), expenditures for hospital care amounted to nearly $13.2 billion. Within 5 years, the annual outlay had almost doubled to $25.9 billion. By FY 1975, annual expenditures for hospital care had more than tripled to $46.6 billion.

Expenditures for Hospital Care
FY 1965-1975

FY	Amount (billions)	Annual % increase
1965	$13.2	---
1966	14.2	8.3
1967	16.9	18.8
1968	19.4	14.6
1969	22.4	15.3
1970	25.9	15.8
1971	29.1	12.3
1972	32.7	12.4
1973	36.2	10.7
1974	40.0	10.4
1975	46.6 (est.)	16.5

Increases in hospital expenditures reflect higher prices paid by hospitals for supplies and services, wage increases for hospital personnel, increasing expenses associated with new technologies and more extensive care, and changes in the utilization of hospital care.

Hospital Costs

The American Hospital Association periodically reports selected data on hospital costs. One of the measures of change in hospital costs is "expense per adjusted patient day." This figure is derived by dividing total hospital expenses by "adjusted patient days," that is, the sum of patient days and patient-day equivalent of outpatient visits. Expense per adjusted patient day has tripled during the last decade.

Expense Per Adjusted Patient Day--Community Hospitals
1964-1974

Year	Expense Per Adjusted Patient Day
1964	$37.58
1965	40.56
1966	43.66
1967	49.46
1968	55.80
1969	64.26
1970	73.73
1971	83.43
1972	94.87
1973	102.44
1974	113.55

Another measure of hospital cost inflation is "expense per adjusted admission," or cost per case after correcting for the costs of outpatient care.

Expense Per Adjusted Admission--Community Hospitals
1964-1974

Year	Expense Per Adjusted Admission
1964	$285.97
1965	310.79
1966	337.54
1967	409.04
1968	471.30
1969	539.25
1970	610.10
1971	675.01
1972	749.47
1973	799.03
1974	885.69

Hospital Utilization

A number of indices are reported as measures of hospital utilization: admissions, patient days, and outpatient visits per 1,000 population; average length of stay in days; and occupancy rates.

Admissions, patient days, and outpatient visits per 1,000 population provides measures of hospital utilization adjusted for shifts in the size of the population. Admissions and patient days per 1,000 population have increased by approximately 13% in the last 10 years. Outpatient visits per 1,000 population have nearly doubled over the same time period.

Admissions, Patient Days, and Outpatient Visits Per 1,000 Population--Community Hospitals 1965-1974

Year	Admissions	Patient Days	Outpatient Visits
1965	138.1	1,072.5	483.4
1967	138.2	1,144.0	563.3
1969	141.9	1,193.2	606.7
1970	145.0	1,197.9	662.0
1971	147.6	1,188.4	726.7
1972	148.7	1,173.6	787.9
1973	152.2	1,190.9	831.7
1974	156.7	1,217.0	901.0

The average length of stay increased in the years immediately following enactment of the Medicare and Medicaid programs, but has declined steadily since 1968.

Average Length of Stay in Days--Community Hospitals 1965-1974

Year	Average Length of Stay
1965	7.8
1966	7.9
1967	8.3
1968	8.4
1969	8.3
1970	8.2
1971	8.0
1972	7.9
1973	7.8
1974	7.8

The occupancy rate provides a measure of the average percentage of beds filled throughout the year. The occupancy rate increased slightly in the 1965-1970 time period but has declined somewhat since that time.

Occupancy Rate--Community Hospitals
1965-1974

Year	Occupancy Rate
1965	76.0
1966	76.5
1967	77.6
1968	78.2
1969	78.8
1970	78.0
1971	76.7
1972	75.4
1973	75.7
1974	76.6

ADDITIONAL REFERENCE SOURCES

American Hospital Association. Hospital statistics, 1975 edition. Chicago, 1975.

U.S. Department of Health, Education, and Welfare. Social Security Administration. Medical care expenditures, prices, and costs: background book. [U.S. Govt. Print. Off.] September 1975.

MEMORANDUM

DATE: September 2, 1976

TO: Michael Lemov

FROM: Elliot Segal

SUBJECT: Possible Examples for Governor Carter; Re: Mismanagement

Attached is:

(1) A short general statement on health care consistent with the Democratic Platform, our Subcommittee work in cost and quality of health care, and failures by HEW to effectively manage current health legislation.

(2) Synopses of five specific case study examples of mismanagement:

(a) A health (actually considered welfare with HEW) case, namely utilization review under Medicaid. The example focuses upon mismanggement and the failure of HEW to monitor cost and quality health care controls. This results in at least $800 million being paid out without evidence that the proper controls required of hospitals, nursing homes, and mental hospitals are adequate.

(b) A consumer health and safety regulation issue. The case illustrates a turkey-meat mix-up, demonstrating bad management and coordination with a compounding of the problem because of a cover-up by FDA of incompetence by the Department of Agriculture.

(c&d) Two economic regulatory examples. One describing a study on clean air by the Environmental Protection Agency (EPA) which illustrates both not conducting the study in a scientific or shholarly manner; and secondly, furnishing the results to automobile companies in order to allow them to make a case against having the appro-

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priate vehicles recalled. (d) The second case refers to the Interstate Commerce Commission (ICC) and focuses upon an internal examination of the compliance program which was described as a "ship without a captain."

(e) An energy example where the Federal Energy Administration (FEA) report on the nation's oil and gas reserves was totally fraught with methodological deficiencies and administrative deficiencies. The FEA Report omitted 28 fields amounting to 3.4 million cubic feet of natural gas.

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Enclosures

Health Care Statement

I. Perspective of Rising Costs

The overall mismanagement and deficiencies found within the administration of HEW, especially the cost and quality aspects of the current health care delivery system, help demonstrate the need for a broad new approach as suggested by Governor Carter; in his call for a comprehensive, universal enfranchisement of all citizens, providing health care as a right and not as a privilege based upon economic status.

--With respect to health care costs, for the twelve months ending June 1975, Americans spend 118.5 billion dollars for health care--up 13.9% from the previous year. Health expenditures accounted for 8.3% of the nation's gross national product, the highest level in history, compared to 5.9% ten years ago--an increase of 41% in one decade.

--The Federal Government spent $33.8 billion in fiscal year 1975 for health. This included expenditures for Medicare, portions of Medicaid, operation of VA and Department of Defense Hospitals and public health service programs.

--In addition, state and local governments spent $16.1 billion for health care in fiscal year 1975; primarily for Medicaid and for public hospitals.

In summary, for fiscal year 1975, 42.4% of health expenditures came from public funds, federal payments for Medicare and Medicaid alone--both under the jurisdiction of HEW--totaled $21.8 billion. States paid out an additional $6 billion in state Medicaid payments.

2. Implications of Poor HEW Management

The 1972 amdnedments (Public Law 92-603) to the Social Security Act included several cost and quality control initiatives for the Medicare and Medicaid programs. These amendments required the initiation of cost programs, monitoring of sound administration by the states, diligent federal management. These amendments include quality measures to establish standards that would eliminate unnecessary hospital procedures, prevent unnecessary and prolonged nursing home stays and create a network of professional standard review organizations (PSRO's). This network of quality

review requires the establishment of national standards and careful monitoring by HEW to insure proper implementation.

No matter what form national health insurancellegislation takes, there need to be quality standards that are included that are included and faithfully executed. The Subcommittee has examined HEW implementation of these quality provisions to date and found them sadly deficient. For example, we focused upon one quantifiable area, namely, unnecessary surgery and found thatbbased upon evidence presented by medical researchers and surgeons; that in 1974 approximately 2.38 million operations costing $3.92 billion dollars were unnecessary. Further, approximately 11,900 Americans died after these unnecessary procedures.

The Subcommittee pointed out to the Secretary of HEW that he has a responsibility under the Social Security Act to monitor quality control provisions such as hospital review committees. In fact, under Sectinn 1903 of the SSA, the Secretary is mandated to receive satisfactory evidence that states have such quality programs for hospitals, nursing homes and mental hospitals. Such satisfactory evidence under the incnetive provisions of the law result in the expenditure of approximately $800 million Federal dollars to states. Secretary Mathews has continued to make these payments without requiring such satisfactory evidence.

3. Health Care Cost Strategy

Currently, legislation exists that has the potential for controlling health care costs. A successful national health insurance program will have to build upon these measures in order to prevent total run away cost and program abuses.

Two steps are now missing that must be carried out in order to affectively control run away health care cost. It is likely that a third step in a form of new additional cost control legislation may also be necessary.

Missing Step One

Step one is enforce the existing statutes. HEW has been particularly remiss in carrying out Medicaid statutes and has also been deficient in PSRO and health planning efforts. The litany of maladministered programs is legion. For example, the Medicaid child health legislation (EPSDT) is directed to diagnosing and subsequentlyttreating children up to age 21. In the 7 years of operation, only 3 out of approximately 13

million children have even been screened. HEW still cannot determine how many children are being treated. In our study, we found 40% of children identified as needing treatment did not receive it.

In studying unnecessary surgery, we found that HEW was not even able to determine how much money was being spent under Medicaid for furgery, demonstrating a total lack of public responsibility. Under health planning laws, HEW has chosen to ignore provisions that build in greater responsibility for state and local governments. These regulations have made it practically impossible for local health service agencies to be public entities. Public agencies represent elected officials, and certainly are more accountable to the public than health care providersdominated groups.

In PSRO's, HEW has for all practical purposes ignored the requirements for nursing homes and ambulatory settings focusing only on hospitals. The current Medicaid scandals are exacerbated because HEW pays no attention to the out of hospital care--like Medicaid mills. But even in hospital reivews, HEW has failed to coordinate concurrent review, medical care evaluations and profile analysis; thereby creating a system of disjointed approaches that will not be able to be evaluated effectively nor will the impact be able to be translated into needed changes in the health care delivery system.

Missing Step Two

The situation needs a consolidated cost control strategy. Otherwise, institutional operating cost, capital cost, and the existing fee for service system will continue the escalation of health cost.

The publicutility approaches encouraged by the health planning act for a six state pilot project must be coordinated with the Social Security Administration prospective reimbursement experiments.

Decreasing unnecessary admissions to hospitals and nursing homes, shortening the length of the stay and eliminating unnecessary services are mandated under Medicare and Medicaid and must be faithfully executed. Implementation of the Health Planning Act calls for approving only needed capital expenditures and controlling the number of unnecessary hospital beds.

Health maintenance organization (HMO) legislation is also designed to effect health costs. By focusing on pre-payment and

early screening and prevention there can be restructuring of payments toward earlier intervention and less expensive ambulatory care. Pre-paid group practice has often resulted in a 30% savings in patient days--a powerful cost control tool.

It appears clear that an overall cost control strategy needs to be developed and coordinated. Without coordination health care costs will continue to rise.

Missing Step Three

Finally, in developing a universal comprehensive national health insurance program, there may need to be an additional legislation for cost controls. The proposed Talmadge Amendments, the Scheuer Fraud and Abuse Amendments for Medicaid, as well as greater incentives for public accountability, as well as added responsibility for state and local government all seem desirable.

Without good management, coordination, accountability and faithful execution; good intentions in the form of comprehensive national health insurance will become a hollow dream.

2(a) HEW

HEW's failure to follow the legislative intent of certain provisions of the Social Security Act leads to inadequate protection of the public. Failure to carry out the utilization control provisions of the Social Security Act (SSA) which was intended to protect recipients of care from "unnecessary and poor quality services" can lead to disabling injuries or unnecessary deaths. The provisions of the law are also intended to curb unwarranted government expenditures.

Most estimates of waste, abuse, practices, and fraud range between $750 million and $1.5 billion a year. Our study of unnecessary surgery suggested there may be close to $1 billion spent on unneeded surgery and related hospital admissions--under Medicare and Medicaid alone.

What has HEW done about this problem?

The following allegations were made in respect to the Department's failure to execute the mandatory utilization control provisions of the Medicaid law. The evidence was based on findings by HEW, General Accounting Office (GAO), and the Oversight Subcommittee of the House Commerce Committee.

--HEW has not complied with the statutory requirements of Section 1903(g) of the SSA, which became effective July 1, 1973. Mandatory financial reductions are called for if states are found not in compliance with the statutory requirements.

--HEW has acknowledged that many states have not met requirements in the statute and regulations.

--As a result, the Comptroller General of the United States is authorized to hold personally accountable certain federal officers, for making payments prohibited by law or which did not represent a legal obligation. It was alleged that the payments made by HEW contrary to Section 1903(g) were serious enough for the Comptroller General to invoke that authority.

In testimony from Secretary of HEW, David Mathews, it became clear that Mathews failed to execute the provisions of the SSA.

In his testimony (portions of which are attached), Mathews admitted that the same states "have not complied with the law." Another HEW official testified that the mandatory reductions

were not enforced for the states that did not comply with the statute and regulations. In essence then, Mathews did not perform his statutory function which required HEW to reduce the federal share paid to states that do not make a satisfactory showing.

Most recently, on August 30, 1976, Mathews has responded to a legitimate Congressional inquiry by the Senate Long Term Committee on Aging by saying that hearings into Medicaid fraud were "grandstanding."

Rather, Secretary Mathews has acted as a "scofflaw" who repeatedly and continuously "flouts" his responsibility.

In fact, the General Accounting Office (GAO) has taken the extraordinary step of putting HEW and Mathews on notice that he can be held accountable for future unsubstantiated disbursements of federal dollars.

(Attached are back up materials--including the GAO letter to Mathews, a newspaper account from the Washington Post, a staff chronology of HEW mismanagement, etc.)

2(b) Turkey Meat Mixup

The Food and Drug Administration (FDA) is required to protect the public from unsafe and ineffective products. Part of this responsibility extends to drugs used in animal feed. When these drugs are suspected or known to cause cancer, FDA sets tolerance levels to insure that residues of carcinogenic drugs are not ingested in food.

In the case of Ipronidazole, a drug added to turkey feed to prevent a disease known as "blackhead," the FDA's Bureau of Veterinary Medicine and the Department of Agriculture failed to communicate effectively when residues of the drug--which is suspected of being carcinogenic--were discovered at higher than legal tolerance levels in turkeys in mid-1975.

A Memorandum of Conference discribes that the Agriculture Department's Animal and Plant Health Inspection Service inadvertently impounded acceptable turkeys, while turkeys from the dangerous lots were combinded with other lots, processed into turkey rolls, and sold. (attached)

It is clear from this memorandum that the Food and Drug Administration inspector discovered a report of Ipronidazole residues in turkeys at a level of 48 parts per million. According to this memorandum, an FDA investigator contended that FDA should assume responsibility for the turkeys that were processed and shipped; Bureau of Veterinary Medicine Director C.D. Van Houweling, however, maintained that primary responsibility rested with the Agriculture Department, and that the Food and Drug Administration should only have initiated action when specifically requested to do so by the Department of Agriculture. Another Food and Drug Administration official said:

> ...we must realize that as the drug residue program is now being carried out by FDA and USDA, there is the possibility that USDA, or for that matter FDA, may be <u>embarrassed</u>-- (emphasis added)

by public disclosure of the incident in the event of Food and Drug Administration legal action against the turkey growers.

During the Subcommittee hearings, Commissioner Alexander M. Schmidt admitted there have been communication problems among the Bureaus within the Agency. FDA and the Department of Agriculture have "concurrent jurisdiction over misbranding and adulteration of meat products after inspection." Therefore, both Agencies are equally culpable in this case.

It is essential that Agency officials maintain a sense of their overall responsibility so that proper solutions are found quickly to potentially dangerous situations. The Food and Drug Administration officials in this case were more concerned with possible public embarrassment thanwwith the maintenance of public health. The failure of the Bureau of Veterinary Medicine to communicate on the life-threatening situation of Ipronidazole borders on the criminal.

Early Periodic, Screening, Diagnosis Treatment Children's Health Medicaid

Summary

EPSDT was expected to provide screening, diagnosis, and treatment of medical needs to children in a coordinated and comprehensive manner consistent with good public health principles. These principles include outreach and follow up activities and treatment when necessary.

The Subcommittee found that the Department of Health, Education, and Welfare was delinquent in faithfully implementing this program in all aspects of the program. The Department focused its activities on monitoring the screening aspects. Even here, however, the results are for below expectations. In fiscal year 1975 only approximately 1,900,000 out of an estimated 12,800,000 eligible children were screened.

Of particular concern is the lack of treatment mandated by the law, but not being provided by the program. When children were determined in nine states to need treatment, these states reported that only 60.4 percent actually received such treatment.

Of equal concern to the subcommittee is the fact that only none states were able to supply and data concerning the treatment of children. The remaining states were neither able to account for the number of children treated nor to account for how the public funds were expended under the medicaid program.

The Department of Health, Education and Welfare has not monitored the implementation of this program with delegence, it has been tardy in promulgating regulations, it has not

undertaken formal compliance hearings in order to bring states into conformity, and it has failed to properly administer the penalty provisions.

The Subcommittee recommends that the Department immediately and fully implement the EPSDT requirements for screening, diagnosis, and treatment of children, and that it utilize the broad powers under the law to secure implementation.

Further, the Subcommittee recommends that the Department initiate steps to eliminate fragmentation, improve its data gathering, and streamline its cumbersome penalty procedures. The Subcommittee also suggests that the appropriate legislative committees consider providing positive program incentives to screen and treat low income children, and to consider new legislative authorities including the possibilities of greater Federal financial coverage or inclusion of the EPSDT program into a national health insurance program.

> We have changed our reporting requirements. We are in the process of getting that cleared through the Office of Management and Budget and we are requiring them not only to report screening data but to develop some mechanism for following up to make sure that the children are treated. 136/

The need for providing follow-up treatment for medical needs which have been uncovered by screening is another specific requirement under the regulations. Section 205.146(c)(V)(3) states that arrangements must assure "that such services are provided or initiated within 60 days of a screening finding that indicated a need for such services except in cases where the State can show that failure to do so is not the result of State inaction." 137/

D. Cost-Benefit Relationships

Several witnesses offered evidence of health and economic benefit payoffs in undertaking an early prevention and treatment program for children. Others questioned the large administrative costs associated with the EPSDT approach and suggested program changes that would lead to reduced spending on administrative aspects. For example, Dr. North testified: "EPSDT is also linked to the special problems of medicaid with its complex eligibility requirements, on and off eligibility, its endless forms, and its late and inequitable payments". 137a/

Witnesses focused specifically on the cost benefit advantages from a public health standpoint. Congressman Ralph Metcalfe(D.-Ill.) testified:

> Dr. Eli Newberger of Childrens Hospital in Boston and one of the Nation's most distinguished experts in the fiedl of child health care, has estimated that a complete preventive child health care, from the time a mother is six months pregnant to the

time the child is 16 years old would cost about $1,000 per child.

"Compare that with the current rate of hospital care and the current cost of drugs," Congressman Metcalfe urged. "That $1,000, which could go a long way toward keeping a child healthy for his entire life, would not even pay for 2 weeks confinement at a hospital at today's prices." 138/

E. Alternative Approach

Dr. North testified that EPSDT as currently defined and administered "has been and will continue to be a costly and ineffective approach to getting these needed health services to the Nation's children." 139/

He suggested that money now spent on EPSDT be relocated to provide a basic minimum program for all children by issuing a set of vouchers to all parents. "Vouchers would eliminate complex and costly billing and payment procedures," he said. Moreover, this approach could cover all 75 million children below the age of 21 at a cost that "would approximate $750 million a year, well within the order of magnitude of what is being spent now in attempting ineffectively to get such services for only a small proportion of the poorest children in the country." 140/ Costs for comprehensive child and maternal care are low, predictable and controllable. Because a child may be able to avoid expensive hospitalization, and because health professionals other than doctors can be used, it has been estimated that the costs of comprehensive child care from birth to age 19 would be about two-fifths of the amount needed by the average adult. 141/

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The Subcommittee is impressed with this concept and believes further exploration of this option should be undertaken. Consideration should also be given to creating incentives, such as increased federal financial participation to those states utilizing a positive approach to the EPSDT program.

In examining other alternatives, it may be instinctive to examine demonstrations such as Cambridge, Massachusetts. That program has shown that a reorganization of existing child health service, often disjointed and duplicative, can provide comprehensive care to an entire community. In the case of Cambridge, a re-reoganization, in addition to the establishment of neighborhood health centers in population centers and the use of nurse practitioners as the primary caretaker was accomplished without the expenditures of any new funds, but significantly improved to child health service.[142]

There are other alternatives to the EPSDT approach currently being proposed. The "Maternal + Child Health Care Act" ~~children and mother's bill sponsored~~ Proposed by Congressman James Scheuer embodies one such alternative. The comprehensive health insurance proposed by Congressman Corman and others as well as other national health insurance proposals would materially affect the EPSDT program.

Since such alternatives require new legislative authority and are currently being analyzed and evaluated by the appropriate legislative Subcommittees, they were considered beyond the purview of this report.

CNHI

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Ray Schoessling

MAX W. FINE
Executive Director

September 7, 1976

Bob Haveley deleted
I have #5, 6, 10 as too
partisan.
Mary

Mary E. King
MARY ~~KING~~ ASSOCIATES
Suite 511 - Headquarters Building
2000 "P" Street, N. W.,
Washington, D. C., 20036

Dear Mary:

The new deadline of today for briefing papers (your memo dated September 2nd) makes it impossible to deliver the material in the format requested. Accordingly, I am enclosing materials which I believe will be useful in any format.

While a number of papers deal with "How Health Security" does this or that, you will find that these as well as the other papers do describe the problems and suggest how they must be handled nationally.

I hope you find the papers useful. They are as follows:

1. Rural Health

2. Urban Health---consisting of testimony by Governor Dukakis and paper by John L. S. Holloman, M.D.

3. The Gap Between Promise and Performance.

4. A Practical Health Problem for the Aged and Chronically Ill.

5. How Health Security Reforms the Health Care Delivery System.

6. How Health Security deals with problems of child care, by W. W. McCrory, M.D.

7. Health Care Cost: A Distorted Issue, by Rashi Fein.

.../2

Charles I. Schottland
David Selden
Albert Shanker
William Sidell
John Siegenthaler

Moyor Harvey I. Sloane, M.D.
Floyd E. Smith
Oren Lee Staley
Jesse L. Steinfeld, M.D.
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The Most Rev. Walter F. Sullivan
Gerald Teplitz, B.S., D.O.
Myron Wegman, M.D.
Jacqueline Wexler
Roy Wilkins

T. G. G. Wilson, Ph.D., M.D.
Leonard Woodcock
Jerry Wurf
Ralph W. Yarborough
Alonzo Yerby, M.D.

8. Health Security and Malpractice.

9. Forward, Cautiously, with Forward Plan for Health, an analysis of the Administration's plan by Daniel S. Greenberg in the New England Journal of Medicine, September 2-, 1975.

10. Tooling Up for Health Security--Health and Construction Jobs which would be created.

11. Remarks by Leonard Woodcock and paper by Melvin Glasser on why Health Security is Good for Working People.

12. Occupational Health and Safety.

13. Some Impressions of the American Debate About National Health Insurance, by William Glaser (no relation) who is publishing a book on foreign health systems.

Sincerely,

Max W. Fine
Executive Director

MWF:pap
enclosures

2.

TESTIMONY OF
GOVERNOR MICHAEL S. DUKAKIS OF MASSACHUSETTS
TO THE
SUBCOMMITTEE ON HEALTH
HOUSE COMMITTEE ON WAYS AND MEANS
DECEMBER 3, 1975

Mr. Chairman, members of the Health Subcommittee: I appreciate the opportunity to appear before you today to tell you why I believe it is essential that Congress approve a comprehensive national health insurance bill.

Let me say at the outset that it is not my intention to comment on the pros and cons of the various health insurance proposals before Congress. Rather, I want to give you an idea of how this problem looks from the vantage point of a chief executive of one of the states.

Over the past year, we have heard a lot of talk from the White House about how the states and localities should take on the responsibility of providing decent health care for all citizens. Apparently oblivious of the fact that the nation's health care crisis is getting worse, not better, the President has shelved even the Administration's limited national health insurance scheme.

I respectfully submit that the President's thinking in this area is 180 degrees off target. Instead of foisting the health care problem on the states, the federal government should be moving aggressively to solve the crisis.

A national program which guarantees decent health care for every citizen -- and the federal government is the only government that can provide such a guarantee -- is long overdue.

Let me emphasize that I do not expect the federal government to solve every social ill which plagues our society. Quite the contrary. The only way we as a nation can deal with the enormous range of social and economic problems which confront us is through a clear and intelligent division of functions between the federal government on the one hand, and state and local governments on the other. The federal government must do what it, and only it, can do well -- and free us at the state and local levels to do what we do best.

Those of us who have been elected to lead our states and cities face a bewildering array of federal grant-in-aid programs, each with its own bureaucracy, forms and regulations. And because this nation has been unable to commit itself to certain basic guarantees -- a job, decent health care, and so on -- we at the local level are flirting with default as we try to cope with problems that are beyond our capacity to solve.

So, while the states and cities are driven to the brink of bankruptcy by their efforts to provide these guarantees, we are robbed of the resources which could make it possible for us to do the things we do best -- educating our children; building decent mass transportation systems; caring for the mentally ill and retarded; creating correctional systems that rehabilitate as well as punish; protecting our consumers with tough and aggressive regulatory laws and agencies; and fighting the staggering rise in crime in our communities.

In remarks to the National Democratic Issues Convention two weeks ago, I outlined the six major areas for which the federal government must take responsibility -- a responsible foreign policy; an economic policy which guarantees a job for every man and woman who is willing and able to work; a decent national transportation system; reform of the tax system; a national energy policy which emphasizes conservation; and a national health insurance system that provides decent health care for our people, whether they live in Massachusetts, Mississippi or Montana.

Every other so-called progressive nation in the world has a national health system -- and those of us in state and local government will surely go bankrupt if we are forced to continue to serve as insurers for hundreds of thousands of our citizens under the Medicaid program.

That is unquestionably the case in Massachusetts, where we have experienced a very rough 11 months as we sought to balance a budget which was hopelessly out of balance when I took office. The combination of overcommitments to various programs and declining revenues forced us to cut our current budget almost $400 million below last year's spending even while we were raising another $350 million in new taxes.

We have had to chop $100 million from the $510 million Medicaid budget, and eliminate all medical care from the General Relief program. The consequences are enormous. The poor and the elderly, two groups which traditionally suffer most because of this nation's inadequate health care system, will be deprived of some of the services so essential to their well-being. No longer will the state be able to pay for occupational therapy, hearing aids, adult dentistry, podiatry or private duty nursing -- and that is only a beginning. Some elderly persons may be forced out of nursing homes; some poor people may go without badly needed surgery and other medical care.

This is inexcusable, but Massachusetts and many other states are powerless to prevent it. If you in Congress follow the President's suggestion and leave solution of the health care crisis to the states, that crisis will only bet worse.

The federal government must guarantee every American the medical attention he or she needs to stay healthy.

At the same time, any national health insurance plan must include cost controls and spending limits. The federal government must take decisive action to deal with the skyrocketing cost of health care. We in Massachusetts are trying to cope with this problem through our rate setting agency, but any efforts we make pale in comparison to the potential for action at the federal level.

The inadequate medical care given millions of Americans -- and the complete lack of any health care for millions more -- are glaring injustices in a land that thinks nothing of pouring fantastic sums of money into military dictatorships abroad, and into swollen defense budgets at home.

A civilized nation cannot bankrupt a family because one of its members becomes ill.

A civilized nation cannot close the doors of its hospitals to those who cannot pay.

A civilized nation cannot leave more than 500 communities without a single doctor.

And a civilized nation cannot deny treatment for drug abuse and alcoholism to poor people who desperately need our help if they are to become productive members of society.

Decent health care is a right of the American people. I strongly urge the Congress to pass a comprehensive national health insurance plan to make this right a reality.

If you in Washington do your part, we in the states can do ours. If you devote your attention to the fundamental needs of the American people -- we can use our resources to do the things which we, at the local level, do much better.

As partners, we can finally demonstrate to our people that government can be an effective instrument for social and economic change.

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JOHN L.S. HOLLOMAN, JR., M.D.

PRESIDENT, HEALTH & HOSPITALS CORPORATION
OF NEW YORK

"HOW HEALTH SECURITY AIDS PUBLIC FACILITIES IN MEETING THEIR RESPONSIBILITIES TO THE POOR AND DEPRIVED"

FOR RELEASE 10:30 AM EDT, MONDAY, APRIL 14, 1975

The various National Health Insurance bills currently before Congress, and those promised by the Administration and others, have different levels of state and local involvement for financing. In my opinion, even though each of the bills would initially relieve the state and local governments of at least some part of their present expenditures for personal health services, the enactment of any of them other than Health Security would be a disaster for many States and local governments. And I'll tell you why.

At the present time, State and local governments are meeting about 11 percent of the $100 billion-plus national expenditures for personal health care. The Federal share is about 25 percent of the total, with the remaining nearly two-thirds made up of private out-of-pocket and private health insurance payments.

Now that the AMA has dropped its Medicredit bill and introduced a bill closely resembling that of the Administration's CHIP plan, we have basically three different proposals for national health insurance. The first is the CHIP approach. The second is the Long-Ribicoff catastrophic insurance approach. And the third is Health Security.

On a national basis, the enactment of CHIP or a similar bill would initially (and theoretically) reduce the State and local share of personal health care costs from about 11 percent to about nine percent of the total. When the total reaches $120 billion dollars, as it will this year according to the estimates, that means a saving of somewhat over $2 billion for the State and local governments. A theoretical saving that is because, in reality, a Health Task Force of the U.S. Conference of Mayors has concluded that CHIP

"would offer no benefit for local governments and underserved populations." And my own analysis shows a similar benefit void for State government.

As you know, the CHIP proposal requires substantial deductible and co-insurance payments. No one is so poor as to completely escape some payments under this bill. For example, a family with only $2,500 annual income would be required to pay per person deductibles of $25 for drugs and $50 for other covered services, and co-insurance up to as much as $225 per year, or nine percent of its total income of $2,500. Now, where is a family with income of only $2,500 supposed to get $225? The answer is "there's no way." The result is that state or local government will have to pay the co-insurance expenses for the needy and medically needy people. Consequently, the state and local share will increase in needy areas. So while on paper, CHIP would reduce the state and local share from 11 percent to nine percent of the total, the fact is that the state and local share will actually increase from 11 percent to 12 or 13 percent, and in large urban areas such as New York City or Chicago, it will go considerably higher.

CHIP is a shell game, and there's no way that the states and local communities where most of the people live can benefit. It may limit the liability of the Ford Administration's budget, but it will wreak havoc with the already hard-pressed health budgets of the cities and states.

While CHIP would be hazardous to our health, the Long-Ribocoff bill would be absolutely lethal. This bill is supposed to take over catastrophic costs and federalize medicaid and thereby, according to HEW, reduce costs to State and local government from 11 percent to ten percent of the total. But Long-Ribocoff will be an open invitation to private providers of all types to raise their fees and charges, on the assumption that when the deductible threshhold is reached, the government will pay. Basic costs will skyrocket and, worse, they will subsidize all the esoteric elements of medical care while further discouraging preventive medicine and early diagnosis of disease. The federalized-

medicaid part of Long-Ribicoff has eligibility requirements so low that they will provide no relief in my own city of New York or similar areas where we have been trying to do as good a job as possible with this admittedly defective program.

Savings to State and local governments -- and taxpayers -- are a mirage under Long-Ribicoff, because even though an oasis may appear on the horizon, it disappears as you approach. On the other hand, Health Security would provide substantial savings. Its overall cost control features are not found in the other bills. Hospital costs are anchored to budgets, pre-determined. Physician fees are tied to negotiated schedules. Other payments are limited and not arbitrarily established by providers. These features apply generally. Specifically for the States and local governments, the savings of redistribution of costs can be clearly shown. In the State of Massachusetts, for example, Governor Dukakis' office has calculated that the $423 million spent by governments within the state in fiscal 1973 would have been reduced to only $149 billion if Health Security had been in effect. The reason is that, by establishing a single national program with universal coverage, the Health Security system would absorb $309 million in costs incurrred by the state and local governments. The same would be true for every State in the union. Under Health Security, the 11 percent of total health costs now met by States and local governments would decline to 3 percent, according to H.E.W.

But there are other levels of consideration for State and local governments. Will national health insurance fulfill the right of the people to adequate health care? Will the program provide comprehensive benefits and thereby increase its potential for improving health status? Will it serve to reform the delivery system? Will it provide for equitable and progressive financing? Will there be strong quality controls? Will cost controls be effective? Will it assure adequate resources to meet the needs of all the people?

Measure all of the national health insurance proposals against these criteria and you will find that only Health Security measures up. It is a national health insurance program of the type which I can support because it will make helath care a right instead of a privilege. It does provide a single financing system for all and not double standards, one for the poor and one for others. It is not merely a financing mechanism; it is a national health program.

Those of us in local government whose responsibility it is to assure that citizens have access to adequate health care, and who provide the services or at least pay for them in part, have long since learned that preventive services directed toward community groups must be included in any national health insurance plan to insure that our goal is preservation of health rather than sickness care. And yet, every major national health insurance proposal except Health Security would impose deductibles and co-insurance as additional barriers to preventive care.

Assurance of quality of care and equitable distribution of resources must be accepted as goals. And yet, they are mere rhetoric, as in CHIP, or completely absent, as in the AMA proposals.

If resources are limited, should they be rationed on the basis of ability to pay? I think not. I think they should be equally available to all, on the basis of the peoples' needs for health care. I think that payment for health services should be on the basis of a total allocating to local regions and areas, an allocation which takes into consideration population, local need and other factors such as environmental, economic and health conditions. Special health problems and the needs of certain high risk populations must be considered.

Finally, I believe in the importance of consumer involvement and public accountability at all levels, Federal, State and local. Only Health Security

builds in consumer involvement on a continuing basis. It is the only program which assures public accountability. It is meant to serve the consumers and not just the providers of health care.

In summary, it is my firm belief that State and local governments would discover they could not live with CHIP or catastrophic health insurance. Frankly, we may not be able to live without Health Security very much longer.

# # # # #

THE GAP BETWEEN PROMISE AND PERFORMANCE IN HEALTH CARE: HOW IT CAN BE NARROWED

There is a wide gap between promise and performance in health care in the United States. We speak of our health system as the best, the most advanced in the world. Yet:

- millions of Americans have no access to health care services
- millions more receive minimal, inadequate health care services
- preventive medicine is non-existent
- we treat disease, we do not maintain good health
- 40 million Americans have no health insurance at all -- and today that figure is closer to 60 million as the number of laid-off and unemployed Americans increases and they lose their health insurance coverage
- those who need coverage the most, receive the least -- the poor have twice as much illness, four times as much chronic disease, three times the heart disease, five times the mental retardation
- accepted health care indices such as infant mortality, maternal mortality, life expectancy show that the USA is further behind the other industrialized countries than it was 15 to 20 years ago

FOR RELEASE [illegible]

Meharry Medical College in Nashville, Tennessee conducted a 2-year research project whose main question was: Does society provide adequate health services to the poor? Their answer was clearly no. Some of their findings in their study of 1,266 poor families in Nashville are:

- 1/2 the persons studies had no health insurance for physician visits
- the people surveyed visited the doctor about 1/2 as many times as the average American
- in those families where medical problems had already been diagnosed only 15% of those persons were receiving medical care

The above are clear ways in which comprehensive medical benefits would be made available to all Americans. Health Security would also revise the framework which supports the delivery of health services. The compenents of this revision are:

A. Administration

Overall health policy would be through a Health Security Board and the Secretary of HEW. There would also be a National Health Security Advisory Council to assist and advise the Board. The Board and Council would control financing, establish benefits, set standards of participation, plan for developments and improvements in health services. The administration of the program would then extend to state, local, regional and health service areas so that the program would be implemented effectively at all levels.

B. Finances

A Health Security Trust Fund would receive and allocate funds. Fifty percent of the monies would come from:

1. 3.5% tax on employer payroll
2. 1% tax on first $20,000 a year in wages and non-earned income
3. 2.5% tax on first $20,000 a year of self-employed income

The remaining 50% would be from general revenues. The monies would be used to pay for all the medical benefits described above as well as for the development of additional health resources and services.

C. Cost and Quality Controls

Cost controls would be built into the system through advanced or prospective budgeting. Each year a budget would be determined and allocated for physicians, institutional and other services in each region. No longer would payment to providers be open-ended and out of control.

A set of national standards for providers of care would be established. This includes physicians, dentists, osteopaths, optometrists and podiatrists. Hospitals, skilled nursing homes, home health agencies, specified drug abuse, alcohol centers, medical or dental foundations, HMO's would be eligible to participate in the program if they met national standards.

D. Consumer Participation

There would be a majority of consumer representation on the National Health Security Advisory Council, assisting the Health Security Board in overall policy-making and administration. Regional and local advisory councils would also have a majority of consumers. There would be public control of the basic health policies and support for consumer-sponsored health programs.

E. Resources Development Fund

Grants and loans would be given to develop HMOs. Monies would be available to train new types of health professionals, allied health workers, to increase the desirability of medical work in rural or deprived areas. In essence, the Health Security Board would consider and then finance new programs and ideas to renovate and improve the delivery of care, not just pay for it.

- 95% of the people studied lacked adequate dental care
- 94% had a nutrition problem

Our medical research is some of the most advanced in the world. We have achieved great breakthroughs and discoveries thanks to our research scientists. All this is due to the well-organized, federally-financed system of medical research, of which the National Institutes of Health is the heart. Prior to the establishment of the NIH the financing of medical research was disorganized, inadequate and through private sources such as philanthropy and academic centers -- making continuing research at the whim of what monies were available or not, at any given moment. Every scientist will tell you that research cannot yield fruitful results without counted-on, continuing financial support in adequate amounts. With the NIH tax-based federal funding was made available for medical research. And a great center for scientific study was opened coordinating research efforts in all parts of the country. The results of this reform in medical research have been outstanding. Between 1950 and 1971, 17 American scientists received Nobel Prizes in medical research. By contrast, in a similar 20-year period (1910-1930), Americans won Nobel Prizes in medicine and physiology only 3 times.

Yet, are the promises and benefits of this research reaching the people in improved health services. The answer is no. It is not our research scientists or institutions that are at fault. It is our delivery system. It is in chaos, it is disorganized, and it is ineffective. We ought to take a lesson from the NIH and the reform of the medical research system and reform our present inadequate system of delivering health care. Health Security does just that.

Health Security will also effectively deal with a problem of recent years which has cut into the continuing funds earmarked for medical research. Because our present health financing system has no cost controls, no budgeting, no planning the expenditures for the Medicaid program increase out-of-control. The medical research community has found itself in the position of competing for federal funds because the Medicaid

(and other federal health programs) are absorbing an increasingly larger amount of federal health dollars. Through its financing and cost controls Health Security will end open-ended spiraling costs and provide funds fairly for both medical research and personal health services.

Health Security would reform our health care system so that the best medical care would be available to all Americans in equal fashion. Health Security would make it possible to bring the promise of medical research to every health consumer.

Under Health Security:

- everyone living in the USA would be entitled to all health care services (with few exceptions)
- all these health care services would be paid for by the Health Security Trust Fund
- no American who needs care would be denied the care required
- there would be no co-insurance, no deductibles, no exclusions, no means tests
- full preventive care would be paid for, and encouraged
- all physicians visits would be paid
- all hospital stays would be paid, with no time limitation
- this includes all laboratory, radiology, and social services
- skilled nursing home care up to 120-days per benefit period or for unlimited time if the home is owned or managed by a hospital
- social care services would be encouraged — grants would be given to local non-profit agencies to develop social care services for the chronically ill, the aged, the homebound
- many other services such as drugs, services of dentists, optometrists, podiatrists, ambulance transportation, psychological counseling, physical, occupational, speech therapies, family planning, drug and alcohol abuse therapy, medical appliances, eyeglasses, hearing aids would all be covered in part or full

A PRACTICAL HEALTH PROGRAM
FOR THE AGED AND CHRONICALLY ILL

Health Security will not solve all the problems of the aged and chronically ill. It is not a panacea. However, it will provide considerably better health coverage than Medicare. And it will create reforms in the health care system and new services which should be particularly beneficial to elderly people and to those suffering from chronic conditions who do not need to be institutionalized.

All of the aged will be covered by Health Security -- no one will be left out.

All hospital costs will be covered -- without a first-day deductible and with no lifetime "reserves" or other limitations except on psychiatric hospitalization.

All physicians' services will be covered with limitations only on solo practicing, fee-for-service psychiatrists. All participating physicians will have to accept payment from the program as payment in full; they will not be permitted to charge patients additional amounts.

Prescribed drugs, eyeglasses and medical appliances will be covered.

Skilled nursing home coverage under Health Security will be provided without limit if the home is owned or managed by a hospital and services are provided under the hospitals' budget - otherwise, there will be a 120-day limit per spell of illness. This provision, it is felt, will stimulate the hospitals to come out from behind their curbstones and build adjacent skilled nursing homes with improved services and quality safeguards not always found in the proprietary nursing homes which today make up 90 percent of the total beds.

In the Health Security bill introduced into this 94th Congress, as opposed to earlier versions, there is a provision for social care services which will potentially help millions of older Americans who do not need long-term custodial institutional care.

The past decade shows almost a 50% increase in the number of persons cared for in nursing homes. This is due to the Medicare and Medicaid programs. However, Medicare and Medicaid restrict the benefits that the aged and chronically ill may receive at home. This is what has forced many people to accept care in nursing homes, forces patients to accept more care than they need -- and increases the costs of health care to us all. A recent HEW study showed that between 14 and 24% of this country's 1.1 million nursing home patients are unnecessarily institutionalized because of the lack of alternative medical care.

Home care offers a less expensive alternative to institutional care when institutionalization is not necessary. The Home Care Association of Rochester, New York, showed an estimated savings of $1,068,000 in 1971 through the early transfer of patients from hospitals to home care programs -- a reduction of 12,579 in-hospital days. Home health programs would cost from $180 to $600 permonth, much less than the $15,000 to $20,000 per year or $50 per day to keep a patient in a nursing home in New York City. The National Association of Home Health Agencies estimates that home care is 3-1/2 times less expensive per patient than hospitalization.

Not only is nursing home institutionalization costly and often unnecessary, it can also be brutal and inhumane to the patient, and a source of greed and profit-at-the-expense of health to the owner. Witness the nursing home scandals now being exposed in several sections of the country.

Great Britain, Denmark, Sweden and Norway all have the policy of providing as much supportive home care as is necessary to enable the aged and chronically ill to stay in their homes.

Some of the advantages of home health care services to the aged and chronically ill are:

- personal independence;
- maintain a sense of well-being, usefulness, relationships with family, friends, neighbors;
- avoid unnecessary and degrading institutionalization;
- lower costs of health care to the aged, chronically ill, and taxpayer;
- reduce the need for costly construction of nursing homes;
- expand less-costly home health service agencies;
- take profiteering out of the hands of nursing home owners.

The increased effectiveness of medical care means that the disabled, the chronically ill and the aged are a larger portion of our population than ever before. Those 45 years or over constitute 1/3 of our population and growth in the older age group (75+) has been faster than ever before. About 80% of the 65+ age group are afflicted with one or more chronic conditions. But in the non-institutionalized population of this age group 82% have no limitation in mobility despite chronic illness. Many could be at home who are now institutionalized if home health care and social care services were available.

Health Security could provide home care services to the aged including the following:

- grants to local non-profit agencies for developing social care services for the elderly at home;
- through its payment mechanisms, Health Security would pay for:
    a. all necessary home health visits, removing the present 100-visit limit under Part B of Medicare

b. day care coverage in day care centers and other facilities

c. homemaker visits, transportation to centers, doctors offices, meals-on-wheels, laundry, medical equipment such as commodes, wheelchairs, hospital beds, assistance with shopping and outdoor walking, telephone, and even family subsidies in experimental programs to care for the elderly in their own homes.

In conjunction with the benefits of the home health care services of Health Security the program also could provide the following through its Resources Development Fund:

- grants to schools of nursing and other qualified institutions for short-term in-service training programs for nurses aides and orderlies for nursing homes - this training would emphasize the special problems of geriatric patients;
- funds for the development of Departments of Geriatrics in medical schools;
- continuing education programs in geriatrics for physicians.

Health Security will recognize the difficulties faced by older people on fixed incomes in meeting premium costs for health insurance. Today, not only is there a so-called "dynamic deductibles" on Part A of Medicare -- which increases regularly -- but also premiums for Part B, as well as deductibles and co-insurance. There are so many gaps that millions of older people have turned to supplementary private insurance policies, with all their confusing and often duplicative benefits, not to mention high premiums.

Under Health Security, there will be no deductibles, dynamic or otherwise, no Part B premiums and no gaps except as the limitation on long-term care might apply.

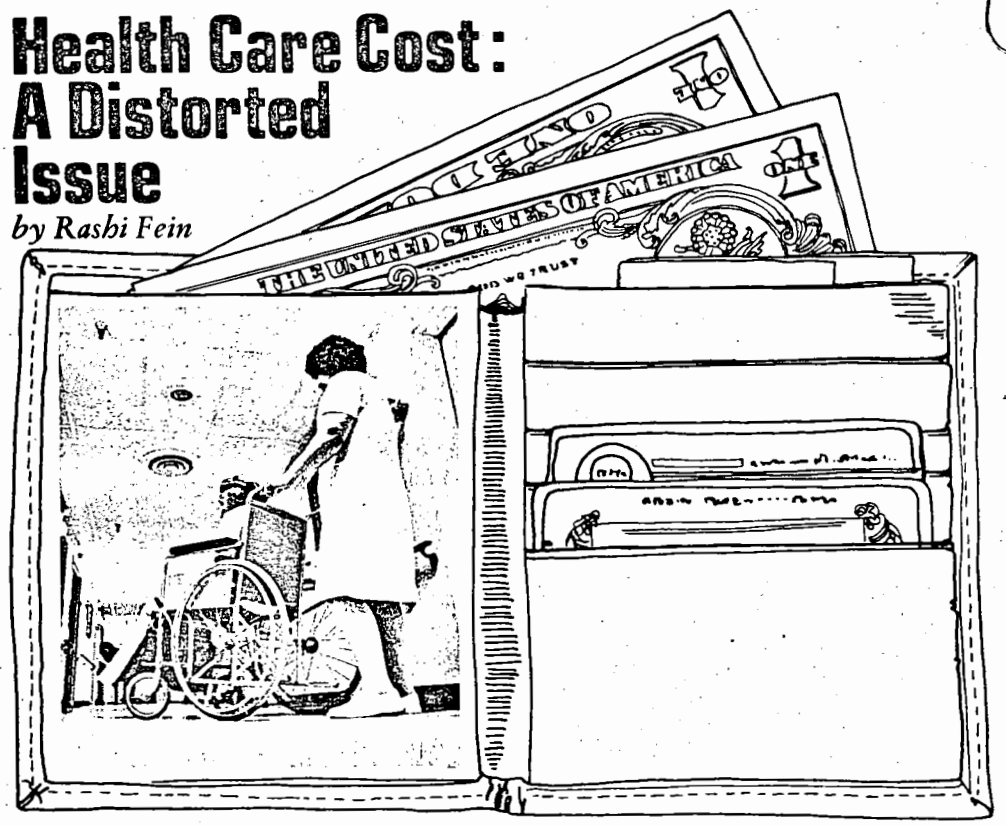
The first $5,000 income from persons over age 60 will be exempt from the Health Security tax, as will Social Security benefits.

As stated at the outset, Health Security will not solve all the probelms of the aged and chronically ill. But it will help a great deal, substantially improving services presently available.

March, 1975

Health Care Cost: A Distorted Issue

by Rashi Fein



All of us who believe in national health insurance because it is comprehensive, universal, fair and equitable are asked one question: "What will it cost; can we afford it?" Some really wonder, and we owe them an answer. But others are asking not because they really wonder but because they want to muddy the waters and cast doubt. They are not interested in an answer; their problem is they know the answer—and just don't like it.

There is an element of dishonesty in some of the language, questions and issues raised by some who oppose national health insurance. Honest men and women can disagree about a number of issues involving national health insurance. We can and should debate matters relating to financing, to private and public mix of funds, to ways of paying for services. There is a lot, legitimately, to argue about.

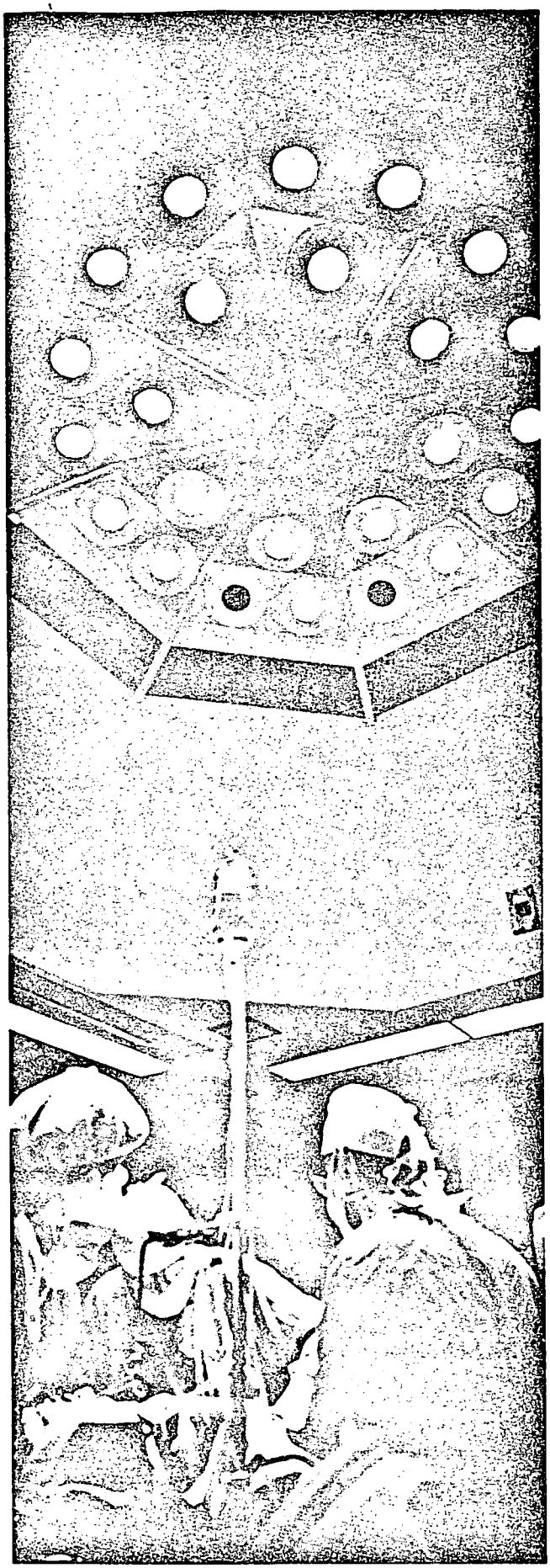
Nor do honest men and women all understand the issues of cost perfectly. But some who do understand the issues correctly use scare tactics about cost to confuse the public. They do not believe their own testimony before Congress, but they hope the public will believe it. We ought to recognize that for what it is and turn our attention to the real task before us—explaining the issues to the American people.

What is the story of costs; what can we afford; what is national health insurance all about in dollars and cents? It may be useful to remind ourselves of the situation as it is today and to consider the situation as it will be when national health insurance is enacted.

We are spending over $100 billion a year in the health sector today. In fiscal 1974, the total was $104 billion, and $97 billion of that was for health care and supplies with the remainder for research and construction. That was money spent—dollars transferred from individuals, insurance companies or government to the health sector, to providers of goods and services. There is an ongoing health activity. It employs over 4 million persons, provides over a billion physician visits and about 250 million hospital inpatient days per annum. The health sector is alive and thriving—at least as measured by the dollars flowing into it, 7.7 percent of the gross national product. It is inefficient. It wastes resources. It fails to deliver care to large numbers of people who cannot afford to pay for services or who do not find services available when and where they need them. But it exists; it is financed; it utilizes resources.

We feel the nation should be getting more than we are for the $100 billion. We should, but that is not my point. What is important for the moment is that there is a $100 billion industry out there. We are not talking of creating a new enterprise—a new health industry—when we speak of national health insurance. It is not as if we have nothing today and want to create 350,000 doctors, 1.5 million hospital beds and all the rest and pay for it. We are not an under-

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developed country without a health care system engaged in a great debate over whether to invest scarce resources in developing personnel and facilities. We already have a system—a $100 billion enterprise.

All that is important because it lies at the heart of one of the significant differences between national health insurance and other proposed government expenditures and programs. It is at the heart of the discussion about costs and what we can afford.

When government spends money for new desks and chairs, for parks or dams, for the CIA, this represents a change in the way resources are allocated in the economy. In those cases, government pays for things that were not going to be paid for by the private sector. When government builds or pays for a dam, it does not ask whether government should pay for a dam or whether individuals should buy it on their own. It asks, instead, whether we should have a dam at all. And it adds a constraint: if we say "yes," it means we will have to do without something else. To ask "should we have a dam" is to ask a meaningful question—for, if government authorizes a dam, it is a new dam that is created. If government puts new money into new programs that deliver services previously not available or delivered, we are talking about new services: parks, roads, inspection, regulation and so forth. New services require new resources —resources that could have been used for other things in the public or private sector.

If, on the other hand, government talks of assuming the costs of services already being delivered and paid for by the citizenry—as is the case with health services—there are no new total dollars or total resources involved. Every dollar government spends on health relieves us, the public, of dollars that we would have spent on health.

There is, of course, a new and different financing mechanism, a new way of spending old dollars, but that is not the same as new dollars. New parks, roads or bombers represent money for things the people would otherwise not have. But medical care is different: we are already spending $104 billion, and private expenditures account for $63 billion of that total.

So the issue is a non-issue. The question can we, as a people, afford national health insurance really means can we afford to spend what we are already spending —and surely the answer is "yes." The issue is not whether we are spending more than we can. The issues are whether we are getting what we should for our money and whether the present arrangements which make health expenditures depend on a family's income are fair, just and humane.

But, the critics say, what about those people who today cannot afford to purchase medical care. Won't national health insurance cost more than we are now spending when it attempts to provide care to those who today find price a barrier? They ask whether we can really afford a universal national health insurance program that brings health care to the forgotten and

the rejected Americans? What does that really mean? Anyone who asks those questions apparently believes that we do not have enough and cannot produce enough medical care services—and that is untrue—and, rather than alter, modify and improve the health care system, prefers to continue rationing health care on the basis of ability to pay—and that is unjust.

In part, of course, the critics say they agree, and that is why they contribute to charity and "support" Medicaid. But, of course, to the extent that charity and Medicaid do purchase health care we are back at square one, talking about dollars that are already being spent. In our view, national health insurance is fiscally a substitute for, not an addition to Medicaid, but it is also different from and better than Medicaid. It is a better way of spending the dollars that are already being spent. No, the reason some of our critics may prefer even Medicaid to national health insurance does not relate to the total dollars going for care. The real reason is some people like the Medicaid system—not because it is efficient, just, humane and decent—but because they feel it is an appropriate system for those whom they consider undeserving. Their chief complaint about it is not that it is a demeaning system in which people are required to trade their dignity for some health care. Their chief complaint is that we are spending too much on it. And when they say, "we are spending too much," they do not mean America cannot afford it. They really mean, "why spend that much on people who aren't making it on their own?"

The fact is that even with Medicaid and other programs, too many Americans still receive inadequate care. National health insurance will permit them to enter the medical care system and will require resources for their care. That is good. That is what we want. That is one of the important reasons we favor the Health Security Act. I am not ashamed of being in favor of decency, humaneness and justice. I am willing to spend dollars, new dollars, to achieve it. In fact, however, I am convinced that we can have a well run system of health care that, by eliminating present waste and inefficiency, can provide care for all the people with fewer resources than are now providing care for only some of the people. For $100 billion we can provide for all 213 million Americans. But even if our critics disagree, even if they argue it will cost more than we are now spending, what would they have us do, continue to deny care to those who need it but cannot pay? Do they really mean we cannot afford it, or do they mean that they prefer not to concern themselves with the problems of the less fortunate?

Unemployment is costing our economy billions upon billions in dollars—aside from the human suffering. Yet we are told the nation cannot provide health care for its people. If we did not have public education, they would tell us we could not afford that either. If we did not have unemployment compensation, they would tell us we could not afford that—or social security or higher education or workers' compensation. Their economic policies cost the nation tens of billions of dollars in lost wages and products and untold human suffering, yet they ask us whether the nation can afford national health insurance.

Yet another argument is used: if government pays for medical care, it is said, you and I will attempt to get more care than we need. We will flood the hospitals and the doctors' offices, inundate the system and bankrupt the economy. But where is the evidence that we are all so in love with medical care that we will face waiting time, travel costs, absence from work, fear and concern to behave that way? The evidence is not found in prepaid group practices where monetary barriers to care have been eliminated or reduced. It is not found in outpatient departments because they have to mount outreach and follow-up programs to get people to use the services. It is not found in the experience of other nations. Canada can manage to meet its commitments but we, presumably, would be unable to meet ours.

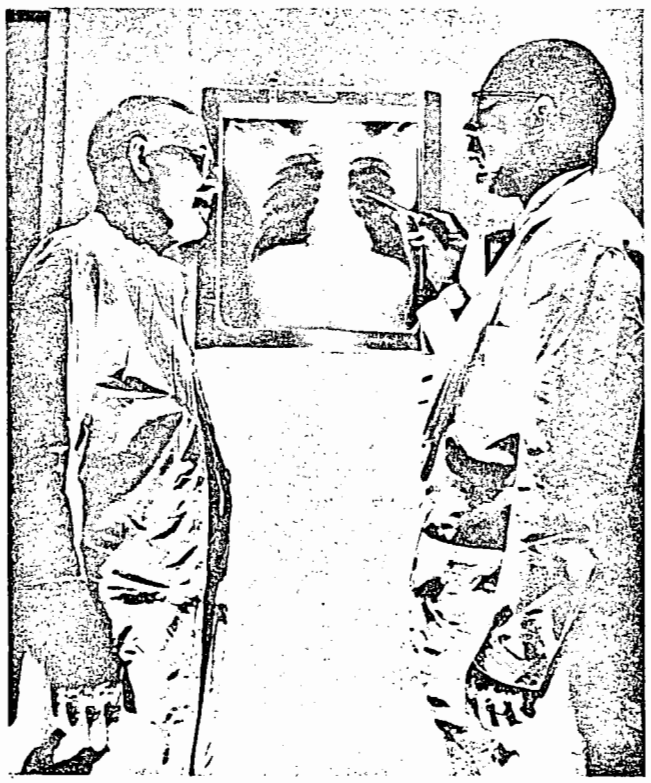
This is the rationale offered for coinsurance and deductibles—for that which is so pleasantly called "cost sharing." Cost sharing is supposed to make you and me behave responsibly, but the real issue is how to induce the system to behave responsibly. You and I do not decide to order unnecessary lab tests; we don't really make the decision that we would like to enter or stay in hospital an extra few days; we are not out there balancing prices and satisfaction and deciding whether we prefer another $10 worth of care or something else. The bulk of those decisions are made for us. High cost sharing is not consistent with the goals and aims of a comprehensive, universal and equitable national health program. Low cost sharing —and that which is low for some is high for others— is not worth the administrative costs. Those who are so concerned about costs might want to join us in eliminating the unnecessary costs involved in administering a system of deductibles and coinsurance. Moving billions of pieces of paper around is expensive—that is waste and, therefore, is something we cannot afford.

At the margin, and for the poor the margin is narrow indeed, price does make a difference. But will the system go bankrupt without price barriers? The U.S. Department of Health, Education and Welfare—a department not known for its support of Health Security—has estimated that the difference in total expenditures—total dollars spent on health, whatever the source of the expenditure—between the Health Security Act and the Administration bill introduced in the last Congress was $6.5 billion on a total estimated expenditure of about $123 billion. We believe that is a substantial overestimation of the costs of the Health Security Act. Among other things, it fails to take account of the very real savings that will come about because of system changes that are part and parcel of the Health Security Act. The HEW estimates assume that the Health Security Act will only

finance care and not change the delivery system, and that is not what Health Security is all about. Nevertheless, even HEW admits that the Health Security Act—even without system savings—would add only 10 percent to what the nation will spend if no legislation were enacted and only 5 percent to what the inadequate Administration bill with cost sharing would cost.

Consequently, we are prepared to argue we can afford a Health Security Act and to argue further that with system change the Health Security Act will save, not cost the nation money. There is surely more than 10 percent waste and inefficiency in the present system.

Is the argument really about going bankrupt because of an additional expenditure of some $6 billion? Can anyone say that a trillion dollar economy cannot afford the Health Security Act? The argument is not really about total dollars and total costs but about where the dollars come from and where they will go. That is the real explanation for the cost sharing and also for the mandating proposals that have been offered by the previous Administration. Requiring that patients pay out of pocket or that employers make health insurance available to their employees is not really cheaper—it only looks that way in terms of federal funds. The dollars all stay in the private sector with mandating, and government does not enter the picture. The dollars are not greener nor are they fewer. But they are private; not public. That is the real issue, and that issue is real because the Health Security Act has a social insurance approach—and it is there for a reason. The fact of the matter is that in health care private financing, operating with private-insurance principles, has not met the problems of the people. We needed social security. We needed Medicare. We got them because those who fought for those programs understood the basic issues involved. The same issues lie at the heart of the fight for national health insurance.



Keeping things substantially as they are or building upon a weak foundation will not lead to universality or equity. The Administration's bill, after all, would transfer only about 5 percent of total costs from the private to the public sector. This is what they call national health insurance—the Federal Trade Commission ought to look into that kind of mislabeling. Is it not equitable to have low-income employees spend a higher proportion of their income on health care via coinsurance, deductibles and premiums that are fixed amounts and do not vary with income or with payroll. It is not universal to have a multiplicity of plans into which people must be sorted. And in dollar-cost terms all this would increase administrative costs. Whatever they may say about the Health Security Act, at least they must admit that its dollars would go for health care and to the health system—not on paper work and to accountants.

In a March 1975 editorial, the Washington Post suggested Congress should examine the true costs of government programs—not just the costs to government, but the real costs. It said: "The argument over health care provides a classic example of the way the present system works. Health insurance plans before Congress are usually discussed in terms of how much they will cost federal or state governments in tax money. While these figures are of obvious importance, the true cost of any such plan must include the additional expenses the plan will impose on employers and employees. If those additional expenses are paid by the employers, they will be reflected, sooner or later, in prices. If they are paid by the employees, they will be reflected in a loss of buying power. In either case, they are real costs, just as tax increases are real costs.

"In order to get a true picture of the full costs of a health plan or noise reduction regulation or any other federal program, Congress needs an 'economic impact' statement not unlike the environmental impact statements now required of many construction programs. Then it could know how much a particular program or set of regulations really costs."

It surely would be advisable if the Administration prepared economic impact statements such as the Washington Post calls for. We who support the Health Security Act would welcome honest analyses—we have nothing to fear and much to gain from public information and understanding. Social legislation—Medicare, national health insurance—is never harmed by public understanding. It is misinformation that is harmful.

Actually, since the federal Office of Management and Budget (OMB) has not been doing what the Post

calls for, proponents of Health Security have done it for them. That is why we know that, in largest measure, the Health Security Act is fiscally responsible. Its economic impact is in terms of equity, not total expenditures. It calls, not for an increase in real costs but, for a shift, a transfer, in expenditures—a shift that is needed and a transfer we can afford. It calls for a social insurance approach.

Thus it follows that the argument that the economy cannot accommodate itself to national health insurance, that it represents an increase in total expenditures and that we have to put national health insurance on the back burner because it is inflationary is false and deceptive. It is an argument without merit, and it does not become any more persuasive when we are told there is no such thing as a free lunch. There isn't, and we know it. But this is a lunch that is already being paid for. In fact, if the Health Security Act were passed and signed into law and if the people who administer it believe in it, the changes in the health care system and in its financing would enable us—for the same money—to have a fine dinner instead of a blue plate lunch.

Recently we were told that the President would veto a national health insurance bill even if spending were delayed a year because enactment of a spending program would encourage an inflationary psychology. If we place the facts before the public and the issues are recognized for what they are—if the public is not misled—no inflationary psychology need result. There are no witches out there, and it is less than honest first to keep frightening us with the imaginary demon of inflation and then to tell us we cannot have national health insurance because some people believe the stories of demons and witches.

Government expenditures on health will go up under the Health Security Act—that is a design feature, not an unfavorable side effect. But private expenditures on health will go down. That is also a design feature. The Health Security Act will be financed out of new revenues which can be obtained in an equitable manner and which all of us will find ourselves better able to pay, in part because we will be saving what we are now already spending on medical care and health insurance and in part because of the growth in tax revenues resulting from the turn around and expansion in the economy. We do not argue that Health Security should come at the expense of other social programs in education, manpower training, income maintenance; we can finance Health Security because we are already financing health care.

Indeed, if people want to talk about inflation, we can respond positively. It is the existing organization and financing of health care that—in the absence of legislation—would continue to contribute to inflationary pressures in the future. The real issue is whether we can continue to afford the waste and inflation inherent in the present system of care and finance. Inflationary pressures, conversely, can be contained and moderated by the kind of responsible intervention that is embodied in the Health Security Act. When it is said that it is automatically inflationary for dollars to be transferred through government back to the private sector for health care, we can respond: "Whose administrative costs are less, the Social Security System which handles Medicare efficiently or the private health insurance sector whose administrative costs are often higher than that of government?"

And so national health insurance is within our means. We are not so poor that we cannot afford one of the hallmarks of a civilized society—the right to health care regardless of income. When all the myths are dispelled, when all the rhetoric and testimony and analyses are over with, we are left with the crux of the matter—the argument about justice for all. Make no mistake about it—the guts of the issue is not about dollars. Those who opposed the Social Security Act, disability insurance or Medicare were not really arguing about money but about how the pie is shared. And the same is the case with national health insurance. The real question is whether resources shall be allocated so that everyone receives his fair share in a system in which the use of medical care is related to medical need, or whether we shall continue, as in the past, to ration care on the basis of income. The answer will be in favor of justice and decency, in favor of national health insurance. A bill will be enacted and will be signed into law.

We must recognize, however, that enactment of a law is only the beginning of a process and not the end of it. The law must be administered. Because we are concerned about cost—about saving money in the health field so that we can devote resources to other social uses, since medical care is not the only unsolved problem on the American agenda—and because we are concerned about equity, all of us will be required to make certain the legislation is administered effectively. Only public vigilance can assure that.

No one will "give" us national health insurance—not the experts or Congress or the Office of Management and Budget. The battle for national health insurance is first a battle for public understanding. Social legislation is not enacted because of the goodwill of special interest groups, but over their opposition. It is not enacted because a few legislators are concerned but because many legislators who would rather sit on the fence find that the pressure of concerned citizens makes fence sitting uncomfortable. We will not convince OMB or the American Medical Association, but we can convince the public.

Thus far, at least on issues of cost, the people have been confused. We have not won the battle of public understanding against those who have sown the seeds of public confusion. I believe it can be won because the facts are on our side. However difficult it is for facts to prevail in a struggle against deception, if enough people work hard enough at it, the public will recognize truth from error. Then, having won the battle of understanding and organization, we will have national health insurance.

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AFL-CIO AMERICAN FEDERATIONIST

4.

HEALTH SECURITY AND MALPRACTICE

(8)

Health Security provides the basis for an economical and long range solution to the malpractice crisis. Unlike other solutions which are superficial and deal only with the symptoms of the crisis, Health Security deals with its causes. It corrects for the lack of quality and cost control in the present system and it removes the financial strain of high medical bills. In short, while Health Security is not a panacea, it corrects system flaws which contribute to the malpractice crisis.

The lack of quality assurance in American health care is one of these flaws. But this is to be expected when licensing standards for physicians vary greatly from state to state, when specialized care is often provided by doctors who are not board-certified in that specialty, when many providers fail to keep their medical knowledge up to date, and when hospital licensing standards are not sufficiently rigorous. Health Security will change all this. It will establish national quality standards for participating individual and institutional providers. Health professionals will be required to continue their education to keep their skills up to date. Standards will be established for the licensing of new providers. These steps will reduce the number of malpractice claims filed for incompetence.

Not only will Health Security improve the quality of medical care, but it will ensure that surgery is performed only when it is appropriate. Recent studies with a New York union health plan have shown that when second medical opinions are sought prior to surgery, effective alternatives to surgery are recommended 17.5% of the time. The need for these second opinions becomes clear when one considers that many malpractice suits result from complications associated with surgery or from unnecessary surgery. By requiring second opinions before surgery, Health Security will not only reduce the number of unnecessary operations performed, but will also ensure that operations performed are medically appropriate. Additionally, since the public will be assured that surgery was appropriate and since the process of seeking a second opinion would better educate the patient to the risks involved, patients would have less motivation to file for malpractice should they be injured.

In addition to mandating second opinions before surgery, Health Security would encourage effective peer review. Group practice would be stimulated, assuming that physicians were on hand to monitor each other's work. Physicians would receive pressure from within the profession to keep abreast of recent clinical techniques and to provide quality and continuous care.

Prepaid group practice plans, the formation of which are encouraged by Health Security, have had lower rates of malpractice, partly because they practice peer review. But this lower rate is also due to the opportunity the organized plans provide for informal consultation among physicians, the representation of consumers on many governing boards, and the effort groups make to handle consumer complaints. By establishing these channels for consumer feedback into the health delivery system, consumer alternatives to seeking malpractice redress are available.

more.....

The patient never being burdened by medical bills would also reduce malpractice. In Britain where this is the case, malpractice is very rare. Whereas 20,000 malpractice suits were filed in the U.S. last year only 281 were filed in Britain in 1973; of these 281 only nine got to court and the doctors won seven of them.

Since patients will no longer be paying their doctors directly under Health Security, they will be less inclined to feel the doctor is financially interested in their illness. The hostility a patient feels when he receives a large medical bill would be a thing of the past. Instead of viewing doctors as bill collectors interested in "taking them for all they're worth," patients might recognize doctors as human beings capable of making mistakes. The patient will have less cause to "get back" at the physician and will be less likely to file a malpractice suit.

It would be naive to say that Health Security provides a complete solution to the malpractice problem. Other concepts such as the introduction of no-fault malpractice insurance, the abolishment of contingency fees for lawyers, and the arbitration of malpractice claims should be considered. But to do this and neglect the need to correct the causes of malpractice would be foolish. That is why we need Health Security.

Many members of the medical profession oppose Health Security on the ground that the government being involved in handling insurance would lead to "socialized" medicine, yet many of these same individuals are asking for federal relief or even governmental provision of malpractice insurance. They apparently feel that aid to beleaguered patients would lead to "socialized" medicine, while aid to beleaguered physicians would not.

The malpractice crisis should teach us that there is a need for reforms in the health care system to help both doctors and patients. The passage of Health Security provides a coordinated and reasoned, as opposed to a piecemeal and haphazard, approach to government involvement. Its passage would provide a lasting and fundamental solution to the malpractice problem, while establishing health care as a right and improving the quality, level and distribution of health care.

September 2, 1975

MEDICINE AND PUBLIC AFFAIRS

DANIEL S. GREENBERG

Forward, Cautiously, with the Forward Plan for Health

The predicament of government health planners is that they have singled out the profit motive as a serious troublemaker in the national health enterprise, and they believe only government can tame it. But they work for a President who is seeking to neutralize the conservative Reagan threat to his nomination by campaigning against government, a tactic that is popular even in the absence of Reagan.

With that background, we are on the way to understanding the mismatch between diagnosis and remedy that characterizes a newly issued and important government document, HEW's second annual *Forward Plan for Health, Fiscal Years 1977-81* (259 pages, single copies available from the Office of Public Affairs, U.S. Public Health Service, Room 5072, HEW North, Washington, D.C.).

The tradition of issuing such plans, if tradition it turns out to be, was initiated by the recently resigned HEW Assistant Secretary for Health, Charles C. Edwards, who departed in December, aggrieved by, among other things, the Administration's denial of much of the money that he considered necessary for implementing his design. Edwards's plan for the next five years of federal activity in health-related matters put considerable emphasis on preventive medicine, along with strengthened efforts for "cost containment" and quality control through such devices as Health Maintenance Organizations and Professional Standards Review Organizations. The rationale for the Edwards design came from a variety of studies that all arrived at more or less the same conclusions — namely, that the costs, quality, and distribution of health care in the United States are excessively governed by an oldtime spirit of laissez-faire. Supporting evidence is to be found in the virtually unrestrained boom in medical costs, surveys that document needless operations, overspecialization, and excessive utilization of hospital facilities. To which can be added overprescribing, zealous pushing of drug formulations of dubious utility, and a general absence of quality review for treatment.

A few diehards still insist that the health industry can right itself without the allegedly clumsy hand of government writing the rules for the practice of medicine. But a broad and widening consensus among practitioners and scholarly spectators now holds that if reform is entrusted to the health industry, there will be little, if any, reform. The Ford Administration's health leadership, under both Edwards and his successor, Theodore Cooper, shares in that consensus, and from this comes the split-level analysis and prescription of the latest *Forward Plan for Health.*

The document candidly acknowledges as much when it states, "This year's *Forward Plan* has not done well in addressing another oft-heard criticism of the last *Forward Plan.* It still does not clearly articulate any set of general principles regarding the differences between the Federal role and State, local, private, and voluntary roles in the health sector."

The need for "general principles," let alone strong intervention, is further testified to by the statement that "The commitment to individual initiative and freedom has permitted the system to tolerate serious imbalances in the distribution of the nation's health resources. The tendency to focus on purely technological solutions to health care problems has created a climate in which the organizational and systems aspects of health care have gone largely neglected. The pattern of increasing specialization has brought with it not only a heightened awareness of the processes affecting organ systems, but also in many instances a reduced awareness of the patient as a whole human being. The uncritical enthusiastic acceptance of new technologies into the health care arsenal, in combination with a general absence of attention to planning, has contributed to rising health care costs. Finally, the unwillingness to infringe on the freedom of health care providers has encouraged a general lack of accountability in the health care system, and this partly accounts for the uneven quality of health care."

And so on, all leading to the grand anticlimax of: "In this view, it is the role of the Federal Government to exhort, support, demonstrate, finance, do research and evaluate; but it is up to the private sector in health care, and the States and localities, to do the actual work of planning and operating the 'health care system.' This partnership offers the best hope for preserving that which 'liberty' and 'equality' should mean in the health arena: individual freedom of choice and action, and equitable access to health care."

Whether or not this presumed partnership does, in fact, offer "the best hope," the authors of the *Forward Plan,* having done their duty for Mr. Ford's anti-government dogma, cautiously opt now and then for the feds going in there and laying down the law. Thus, in the passionless prose that is usually employed by bureaucrats who wish to conceal strong feelings on controversial subjects, they blandly observe "After considerable debate, there is growing recognition of the need for a greater degree of responsiveness and accountability to the public on the part of the major actors in the education and practice settings. This is tied to the realization that the Federal government subsidizes approximately 50% of the total cost of health professions education. Particular strategies have yet to be agreed upon, but there appears to be fundamental agreement that greater controls must be built into the system in order to redress some of its more critical problems."

Which is a soft way of saying that, since the federal government is the largest single source of financial support for training the health professions, it need not content itself with merely exhorting, supporting, demonstrating, financing, researching and evaluating. It can, as it is in the process of doing, prescribe regulations that will ultimately have profound effects on the training and distribution of

medical professionals. But of such matters the health planners may not speak too loudly.

The section of the *Forward Plan* that is devoted to prevention is one of the most provocative, for it explicitly takes on the touchy problem of how far government ought to go in preventing people from harming themselves. In their proposals for federal activity, the authors convey the impression that they believe government ought to go a long way, but here, too, the remedies are a bit more drastic than the timid prose suggests.

It is noted that "as far as government actions are concerned, the proposals are intended solely to provide opportunities and incentives for people to assume full responsibility for their own health. Even so," the *Plan* continues, "it is clearly appropriate to provide for public discussion of such options."

On smoking, the options for promoting individual responsibility include "restricting the sale of cigarettes with high tar and nicotine content," and legislation to "Ban cigarette advertisements or exclude such advertising as a deductible business expense for tax purposes."

Regarding alcohol, one of the options is to "Reduce the alcohol content of certain beverages."

On automotive safety, one of the options is mandatory use of safety belts and a requirement for "those who are convicted of drunken driving, and any driver with a certain number of violations, to reapply for a license every six months and enroll in a safe driving course."

The good sense of these cautiously introduced "options" cannot be disputed, but, then, in the present political environment, their chances of gaining presidential support is miniscule. (It is enchanting to speculate on the political explosions that would ensue from a White House endorsement to cut the alcohol level of whiskey; in a nation that enduringly tolerates the handgun, there is no political profit in tampering with so fundamental a commodity as booze.)

One of the bonuses to be had from perusing the *Forward Plan* is that it is dotted with illuminating health-care statistics distilled from a large array of studies. Thus, annual national spending on health has risen from $12 billion to $104 billion since 1950; between 1950 and 1970, the proportion of GNP devoted to health care rose from 4.5 per cent to 7.2 per cent. After that, it leveled off at about 7.7 per cent, but estimates for the last fiscal year put it at 8.3 per cent.

Of the $104 billion for health care, hospital expenditures accounted for $40.9 billion; physicians received $19 billion.

The *Plan* reports wide regional differences in the ratio of nursing-home beds to population. In 1973, for example, there were 70 beds per thousand persons over the age of 65 in New England, the West North Central, and the Pacific census divisions; however, there were only 40 per thousand in the South Atlantic and East South Central divisions. The *Plan* notes that "The causes and consequences of this variation are not at all clear."

It also reports a rapid increase in the number of active physicians, as a result of new medical schools, expansion of existing ones, and "an appreciable increase in the number of foreign-trained physicians in the United States." And it concludes that "Assuming no marked shift in the size of medical school graduating classes, the addition of foreign medical graduates to the U.S. stock, and the fertility rates of the population, the physician to population ratio in 1990 might be as much as fifty per cent greater than it is today."

Another interesting statistic is that, whereas the number of practicing physicians increased between 5 and 10 per cent between 1971 and 1974, "the aggregate number of physician contacts, excluding those with hospital inpatients, has remained almost constant at about one billion contacts each year." The authors speculate that the cause of this stability might be more time per patient or less time for ambulatory patients, but they go on to observe, "There is evidence from other countries, notably Canada and Sweden, that physicians tend to reduce their working hours in response to the possibility of increased hourly income." The near-extinction of the housecall is also reported, down to only 1 per cent of all visits, as compared with 5 per cent a decade ago.

The large increase in medical costs in recent years is an international phenomenon, with France and Sweden cited as examples; in both, the annual rise since 1965 has been 14 per cent.

As for health insurance, the *Plan* reports that in 1972, about three quarters of the population under 65 had "private health insurance of some type." But among persons 45 to 64 years of age, "only half of those in families with less than $5000 have health insurance while over 90 per cent of those in families with incomes over $15,000 have insurance."

On federal financing of health research, the numbers, which presumably are accurate, indicate that the falloff in support is appreciably greater than heretofore reported. Citing the Office of Management and Budget as its source, the *Plan* reports that "Federal expenditures for health-related research will total just over $2.5 billion in FY 1976, down from $2.6 billion for FY 1975, and the $2.8-billion outlay for FY 1974." When the inflation of recent years is taken into consideration, there is apparently corroboration for researchers who contend that, in terms of purchasing power, federal support for biomedical research is currently back to where it was in the early 1960's.

A final item, one that is outside the generous subject boundaries of Medicine and Public Affairs, but that is worthy of examination as an example of the bizarre prose productions of which officialdom is capable. Our text for today is taken verbatim from an obscure publication of the U.S. General Accounting Office, *Monthly List of GAO Reports:*

"Rear Admirals are divided into two classes for pay purposes — lower and upper half. They are advanced to upper half when their service in grade is longer than half of the total number of Rear Admirals.

"Such an Admiral mandatorily retired on the last day of the month while in the lower half may not compute his retired pay as if he were upper half based on the fact that upper half admirals retired on the same day in sufficient numbers to qualify him for upper half had he been in active service on the first day of the next month."

We can reliably report that the authors of the above have nothing to do with medical matters.

Remarks*

By Leonard Woodcock**

(11)

On behalf of the Committee for National Health Insurance and the Health Security Action Council, I would like to welcome you to this conference. We are meeting under unusual circumstances in Washington: the Congress and the President are in town at the same time. Moreover, for the first time, both are engaged in developing budgets. We already know about the President's budget; there is a right and wrong handle to everything, and the OMB still hasn't figured out which is which. The Congressional budget resolutions are due from the House and Senate Budget Committees this week. We hope they will promote far greater stimulus to the economy than the Administration proposes. We do not anticipate their enlistment in the Administration's budgetary war on the elderly and the poor. And we certainly expect them to give a lift and not a drag to national health insurance.

In recent weeks the nation has been treated to the extraordinary spectacle of the Secretary of Health, Education and Welfare testifying against health on both sides of the Capitol. Secretary Weinberger, in the great cabinet tradition of Earl Butz, has even rejected extension of health benefits for the unemployed. All other witnesses have testified in support of legislation in this field. They see a pressing human need. All recognize there are inequities, there are defects, and there are problems. But even the American Medical Association supports emergency, stopgap legislation. Republicans and Democrats, liberals and conservatives, have introduced bills. With such wide support, wouldn't you feel that differences could be temporarily set aside and legislation enacted to provide that those who are losing their jobs should not also be deprived of their right to health care through private health insurance?

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* Prepared for the Health Security Conference/Rally sponsored by the Committee for National Health Insurance, April 14-15, Washington, D.C.

** Chairman, Committee for National Health Insurance, President United Auto Workers

Secretary Weinberger's answer is "no." He is opposed to health benefits for the unemployed. By his reasoning, it is unfair to help some of the people unless you can help them all. However, his testimony was not disrupted by any ideas about how to help them all. He saw insurmountable administrative problems. Government, said the Secretary of Health, Education, and Welfare, can't administer health, education, and welfare programs. By this, he seemed determined to prove his total incompetence.

I would say to Secretary Weinberger that, if he can't administer these programs, he should step aside and let someone in who can. His no-plan won't play in Peoria and not in Grand Rapids, either. I certainly expect that this Congress will not be diverted by the Administration's opposition from its mission to provide health benefits for the unemployed and, immediately following that, to proceed to enact a comprehensive, universal national health insurance plan.

This is the Congress of the BiCentennial. There are special reasons why it should act. Two hundred years ago, our nation was founded on certain principles and defined rights. "To Provide for the Common Welfare." "Unalienable Rights" -- among them, the rights to life and to the pursuit of happiness.

Have we provided for the common welfare when adequate health care is not available to the American people? Every other industrialized nation in the world has a national health insurance system; Germany's is almost 100 years old.

Does a sick child have an equal, unalienable right to life and to the pursuit of happiness when his family lacks the resources to provide for the care which will make him well? And this in a nation whose doctors are among the most competent and skilled in the world...a nation which boasts the finest medical institutions...which spends a larger share of its Gross National Product for health care than any European nation...but in which infant mortality is higher than 16 other nations, even including Hong Kong and East Germany, and where male life expectancy at birth is less than in 21 other countries, all with national health plans?

We are meeting in the nation's Capitol on the eve of the BiCentennial. But to date, the 93 Congresses which preceeded this one have failed to provide for the American people what every other modern nation has granted to its people.

It's all very well and proper to send a train around the country to let the people see some of the historical papers from the Archives. It's nice to set up tourist information centers and to have special band concerts. But I propose that this Congress memoralize the BiCentennial in a real and lasting way by enacting a National Health Security bill before adjourning!

There can be no more fitting observance of our 200th birthday than to finally translate those aspirations of the Patriots -- "unalienable rights" to life and the pursuit of happiness -- into a reality through National Health Security.

The Ways and Means Committee in the House is scheduled to move into consideration of national health insurance within the next three or four weeks, according to its Health Subcommittee chairman, Congressman Rostenkowski.

I think we need to help them over two big hurdles which they seem unable to clear all by themselves. The first is the one already alluded to: the fear generated by Mr. Weinberger and others that government can't administer national health insurance. Government certainly has been able to administer national health insurance in many other countries, including Canada which at first turned the problem over to private health carriers but quickly found that government could do the job better and at less cost. Canada's national health insurance plan is now administered by government, without a need even for fiscal intermediaries. If any Congressional committee has reason to know that Social Security can be relied on to complete its mission effectively and humanely, it is the Ways and Means Committee.

I see no reason why objective members of the Ways and Means Committee would question the capabilities of Social Security to administer a Health Security program.

But there are many reasons to question the capabilities or the will of the private health insurance industry. The questions are based on 40 years of failure.

After 40 years, the private sector has failed to provide universal coverage; they have only provided a lot of non-traceable figures which even HEW now questions as bloated estimates of coverage. In truth, at least 60 million Americans have no health insurance coverage at all or of such questionable quality as to be absolutely useless except for paying unnecessary premiums.

After 40 years, private health insurance has failed to provide comprehensive benefits. Only one-fourth of all health spending is met even today by private health coverage of all types.

They have failed to control costs which again are escalating 50 percent faster than the general runaway inflation. They have failed to control quality.

Private health insurance has worked very well for the insurance companies, the doctors and the hospitals, but not equally as well for the consumers.

The second hurdle that Ways and Means will have to clear is the myth that Health Security costs too much. Isn't it time that those who created the myth stepped forward and told the truth? They know as we do that all the national health insurance proposals would cost the same at the outset. The main question is: should most of the money be paid through the insurance companies or through a government trust fund. We favor a trust fund for leverage in improving the delivery system, for cost and quality controls, and for competence of administration. The AMA favors the insurance companies for no change in the delivery system, for no cost or quality controls and for incompetence of administration. They want patients to process their own claims and pay fees which go beyond what their insurance will cover. They don't mind the paperwork, so long as the color is green.

I am looking forward, as I know you are, to Dr. Rashi Fein's discussion tomorrow on the myths and realities of health care costs. One of our most important jobs upon leaving this conference will be to carry the message of the real costs of Health Security and of other proposals to the people we represent, and to those who represent us.

The Conference has been structured to discuss substance, strategy and action to achieve a decent national health plan, in this Congress, for all Americans. We believe this Congress offers the best opportunity yet presented for national health. But it is important that the members become fully educated to the differences between the proposals. The AMA has abandoned its old Medicredit bill and now favors the old Nixon bill. They call it the "Health Care Insurance Act of 1975." Like the Administration's CHIP plan, it calls on the Congress to enact a law to confiscate wages to buy third-rate insurance policies from companies which have no interest in controlling fees. They ought to call it "The Physicians' Relief Act of 1975."

The Congress also will need to know more about catastrophic health insurance, and what's wrong with it. This idea apparently has great political appeal, and the Congress needs to be disabused of the notion that catastrophic coverage would be a politically-acceptable compromise. If they look closely at the provisions of catastrophic insurance, they would see this as a wrong idea.

Dr. Axelrod of Ann Arbor was telling us about the patient who received a prescription for eyeglasses. Two weeks later, the doctor saw the patient on the street. He was wearing glasses, but without lenses, only frames. The patient explained that he couldn't afford the glasses, "but this beats nothing."

Catastrophic insurance may beat nothing, but not by much. What good is insurance if the patient first has to pay $8,000-$9,000 in bills before he receives any benefits?

I know many of you are planning to visit on the Hill while you are in Washington. If you should chance upon a congressional tirade against socialized medicine, I would recommend that you carry on your work without disputing the congressman. You may stumble across the Office of the Attending Physician whose doctors and medical corpsmen have a mission to treat members and their families. You may even find a member headed for Walter Reed or Bethesda Naval Hospital. But I don't think we should pressure Congress into accepting their social program for everyone.

In Health Security, we have a program that is better and far less costly.

# # # # #

April 7, 1975

Why Health Security is Good for Working People *

by

Melvin A. Glasser

Many social problems -- this one we can handle -- have know-how -- already spending the money -- Health Security would not spend more, but much, much better.

First a quick look at the six principal problems of our health care system.

1. No National Health Policy: No priorities.... spend more money on preventive programs which would save hundreds of thousands of lives. Programs all over the lot, Medicare, Medicaid, Veteran's, CHAMPUS, MCH -- 26 billion for private insurance with its Swiss cheese coverages -- costly, wasteful, and 40 million people, including millions of workers and their families are left out entirely.

2. Skyrocketing Costs: 104 billion -- 7.7% of GNP.
Costs increased more than twice the increase in COL index between 1967 and 1972 -- in last two months escalation is back to that rate (.6% for general COL index -- 1.3% in medical services index).

   Chrysler worker - family coverage - 1 month's wages; by 1979 -- 2 month's wages

3. Lack of Access: To needed services by significant portions of our population -- low income workers, the poor, ethnic minorities, those who live in the urban ghettos and the rural areas.

   Too many specialists -- not enough family practitioners -- the doctors gravitate to the suburbs. In Inner City of Detroit 15 physicians serve more than 200,000 people -- in Harley, N.Y. 100 doctors for 400,000 people.

   Is it any wonder that when Meharry Medical College recently conducted a study of over 1200 households in the Inner City of Nashville, Tenn.,

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* Health Security Rally - April 14-15, 1975, Washington, D.C.

that only 13% of those requiring medical care were getting the care they needed?

The solo practice system wastes physicians -- costs almost $100,000 to train a doctor -- AMA Task Force - 50% of time caring for patients.

4. Inadequate Quality: Ranges from superb to horrid. Health status -- 18th in infant mortality -- half of countries behind us 25 years ago are now ahead of us.

Twice as many surgeries.

Doctors like patients are locked in by present system to treating episodic or catastrophic illness.

5. Inability to Provide Coverage for Health Care When Most Needed -- During Unemployment and Economic Recession.

6. Interrelatedness of the Above Five Factors: The Health Security program is the only proposal before Congress which would deal with these problems in an integrated way -- which is the way it must be done, if the problems are to be solved.

Workers must be helped to understand there is no other effective way to provide comprehensive protection to workers' families. It cannot be and is not being done by negotiated programs alone through the collective bargaining process.

Specifically then, What's In Health Security for a Union Worker?

1. It's a better way to get health care for the whole family. Health Security would provide comprehensive benefits for everyone. Billions of dollars diverted annually from wages for negotiated health programs could be spent for improving wages, pensions,

shorter work weeks and the like.

UAW negotiated health insurance premiums last year cost one billion, three hundred million dollars.

2. It would eliminate the major disparities among union negotiated programs. Unions in the economically strong industries have much more expensive and hence better coverage health insurance than those in the less prosperous industries -- e.g., auto, steel, machinists. And the workers with the poorer coverages today are more likely to have the greater need for health services.

3. It would, in most instances, cost workers less for comprehensive Health Security services than they are paying today through premiums and out of pocket fees. Under Health Security workers would pay 1% -- employers 3 1/2% -- balance from general revenues. This 1% is equivalent to what workers are already paying as Medicare tax.

But very few workers today are covered for the range of services Health Security provides. And today they are not protected from excessive price increases in health care services. Health Security provides that protection through annual budgets and effective cost controls.

4. It would provide a fairer and less regressive way of paying for health care. Today an employed person earning $6000 per year and one earning $60,000 pays the same premium for the same private insurance coverage. Through the Social Security tax and the general revenue contributions, those earning more would pay proportionately more to support the program.

5. It would once and for all remove from workers the fear that if they lose their jobs they would also lose their family health insurance protection.

6. It would take off the collective bargaining table, efforts, which are being increasingly frustrated, to improve benefits. First Health Security benefits are comprehensive. Second, because of runaway costs, it is becoming more and more difficult through collective bargaining, to add major needed improvements in health programs.

7. It would provide an important new mechanism to improve access to care -- including HMO's and other new ways of organizing such care -- something collective bargaining can't do -- Resources Development Fund.

8. It would assure workers that there is a meaningful objective program to review and protect the quality of the services they are receiving. Today workers and their unions are helpless to assure quality of care.

9. It would bring unionized and non-union workers closer -- through in health care eliminating the widening gaps between the "haves" and the "have nots". This is particularly true of the ethnic minorities.

10. It would give workers and other consumers an effective voice in determining the policies of the new programs -- at the federal, regional and local levels. Today the consumer pays for the services, receives them, and has practically nothing to say about how they are offered, by whom, and under what conditions.

In summary, Health Security would replace the present priority system where the special interest groups, the hospitals, the doctors, the private for profit nursing homes and the insurance industry make the decisions on the principle of what's good for them is good for America.

Health Security believes one self-interest group is entitled to priority --

and that is the people. This is a good trade union principle. It's a good American principle.

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William A. Glaser
August 8, 1976

AUG 18 1976

SOME IMPRESSIONS OF THE AMERICAN DEBATE ABOUT NATIONAL HEALTH INSURANCE

Following are preliminary thoughts about the discussions and proposals in the United States, in the light of foreign experience in national health insurance. I am currently still doing field work in Europe about how foreign programs actually work.* When I write my final manuscripts in late 1976 and early 1977, I will offer more detailed comments about pending legislation. Some of the following statements might be revised then.

I have been summarizing my findings about foreign systems in a mimeographed monograph entitled Paying the Doctor under National Health Insurance: Foreign Lessons for the United States, second edition, dated July 1976.

The role of the government. Some Americans denounce national health insurance on the grounds that government will "take over" medical practice and make doctors employees of the State. But this confuses "national health insurance" with a "national health service."

1. Under national health insurance, taxes are levied on employees and their employers, the proceeds are deposited in special funds, and the funds pay for medical care. This system is a way of paying doctors and hospitals,

*The research is supported by Grant 10-P-57847/2-02, Office of Research and Statistics, Social Security Administration, Department of Health, Education, and Welfare.

which are left in their customary organization. It does not reorganize doctors and hospitals under a government department. National Health insurance is the system in Canada and Continental Europe.

2. Under a national health service, medical care is financed from the national treasury. Usually only payers of payroll taxes and their dependents can draw benefits under national health insurance, but every citizen by right can use a national health service. Medical care is organized under a government department in a national health service; the hospitals and many other installations are owned by national or local governments. Doctors may remain private contractors who sell their services to the national health service, as in Great Britain. Or, doctors may be civil servants employed by government, as in Eastern Europe. Among developed countries, only Britain has a national health service.

The American debate should focus on how to organize health insurance, and not veer off to the demerits of government control and of government employment, since there is no chance of a national health service here. Americans are misled by the fact that Britain's is virtually the only foreign medical system they hear about, because of the absence of a language barrier. Britain's experience with a national health service has little relevance to the United States.

The carriers. As a general rule, the pre-existing insurance funds ("sick funds") survive under national health insurance. The widespread American belief that they are replaced by government agencies is not universally correct. (However, this has happened in Canada.)

The carriers are transformed into public non-profit corporations. They are subject to public regulations, but the degree of government supervision and the content of the rules vary widely among countries. If America follows foreign experience, the following will probably happen:

1. The sick funds will become larger and more prosperous. Their membership will increase. The flow of payroll taxes (instead of voluntary premiums) will make their incomes larger and more predictable.
2. All must offer a basic list of benefits by law. Coverage of a person and the benefits are not left to collective bargaining between employers and trade unions, as in several pending American bills. The sick funds abroad can offer additional benefits if subscribers pay extra premiums directly to the carriers and/or if subscribers share costs.
3. Sick funds must accept any eligible applicant. Experience rating in membership and in premiums disappears at once.
4. Their governing boards and many of their procedures will be prescribed by law or by administrative regulation by the government.
5. Health insurance is usually separated from other insurance--i.e., the sick funds offer nothing else. However, as the Swiss experience shows, a system can allow a carrier with multiple forms of insurance to offer health insurance under the statute. But this is unusual.
6. Sliding scales of premiums and benefits according to the subscribers' incomes disappear sooner or later.
7. Completely private health insurance continues to be offered by for-profit companies. They cover the elite, which often is not included under national health insurance. Or, they offer extra benefits, such as private hospital rooms.
8. All persons are covered continuously. Payroll taxes are levied on them and their employers at all times. Coverage does not lapse, because persons changed sick funds or stopped paying premiums. Most bills now pending in Congress are not really national health insurance but are methods of strengthening

the existing private health insurance system. Nearly all depend on insurance policies and do not protect persons from lapses in coverage.

Practice of medicine. Many Americans think national health insurance will reorganize the doctor-patient relationship. The encouragement of HMO's under the Kennedy-Corman Bill is based on the argument that national health insurance will be too expensive or too inefficient unless the delivery system improves. But this is very unusual abroad: national health insurance is a method of guaranteeing payment for care and usually says nothing about delivery methods. As part of a political deal to persuade the medical profession to cooperate, the statute usually includes specific clauses forbidding the sick funds to organize facilities and leaving forms of practice to the discretion of the doctors.

However, some persons abroad think that reorganizing the delivery system as part of national health insurance might be a good idea. They believe that insurance has merely frozen a deficient status quo and has enriched the providers.

Payment. Most Americans still shrink from mandating prospective payment. Some critics assume that government dictation is the only alternative to the providers charging either what they want or imposing "reasonable charges" to retrieve costs. They think that fee schedules are proclaimed by governments or sick funds.

No national health insurance system operates with retrospective payment methods or with a commitment to pay the costs incurred at the provider's down discretion. Each uses prospective payment; nearly every one pays the doctors according to a fee schedule. Budgeting and administrative order are impossible otherwise.

No fee schedule is dictated by government or by the sick funds unilaterally. All are negotiated by the medical association and the sick funds. The statute provides for negotiating machinery about payment and many other aspects of

fund-provider relations. Negotiating procedures are one of the most serious omissions from the pending American bills. Americans have thought hardly at all about the negotiating methods that are integral parts of social programs in other developed countries.

Fluctuations in assignment, as in American Medicare, are not possible abroad. A doctor participates in national health insurance for all his eligible patients, or he practices completely privately. He does not change from bill to bill or from patient to patient.

Americans seem to take for granted that doctors can charge what they like under national health insurance: if the fee schedule seems insufficient, the doctor charges the patient at a much higher rate, and the patient collects the official payment from the sick fund. Sooner or later in every country, the medical profession is required to conform to the official fee schedule. Often during the showdown, the medical profession calls a strike against the national health insurance program. But price controls are inevitably imposed. Usually the sick funds and government sweeten the pill by granting much higher fees, and the doctors can earn much more than before. Unlike the pending American bills, the obligation to follow the fee schedule is specified in the statute. If a doctor disagrees, he can practice privately, but few do.

Extent of coverage. A few American bills provide only catastrophic insurance. In practice, this would cover only a few people, although it might alleviate many anxieties. No system abroad has ever been limited to catastrophic insurance. National health insurance abroad covers all acts, without even small deductibles.

Several American bills (such as Long-Ribicoff) cover home health services and nursing home care. Many foreigners wish their systems had included such programs from the start. They are being added only now. Meanwhile, national

health insurance abroad has paid only for office care and hospitalization, with an excessive use of acute hospital beds.

Coverage of specific fields. Several American bills include psychiatry. Once, few foreign systems paid for psychiatry, and these specialists had to practice completely privately. Several foreign health insurance programs now include it but limit the number of visits, out of fear of "provider-induced demand" and endless utilization by patients.

Some American bills cover preventive medicine. Once foreign office doctors did little of this. Recently, a few insurance programs have added preventive examinations to the fee schedules at rates high enough to motivate the doctors. The result in Germany has been widespread screening, a great increase in doctors' incomes, and little accurate case-finding. Office practice--particularly by general practitioners--may not be the most economical and the most clinically efficient vehicle for preventive medicine. A method for identifying persons most at risk seems a more effective method of screening for cancer than inviting everyone for an annual examination.

Laboratory and X-ray may not be medical care that should be paid under fee schedules but may be a species of industrial work that should be covered by statutory clauses other than those relating to clinicians. Large financial windfalls are now occurring under fee schedules abroad, because of automatic equipment and extensive use of technicians, when the fee schedule originally assumed all the work would be done personally by the doctor. The committees that negotiate fees abroad constantly revise the rates for laboratory tests and X-rays, but a more fundamental remedy is needed.

Dentistry is included under several American bills. It has been added to national health insurance in several foreign countries. Usually dentistry is

added without forethought, under the assumption it resembles medical care. But it does not, and it unstabilizes insurance accounts. Utilization of medical services increases only slightly during the first years of national health insurance, because patients were going to doctors privately. But many dental conditions are not treated privately, and adding dentistry to national health insurance precipitates a sudden large increase in demand, long queues, and a great rise in dentists' incomes. Therefore, dentistry should be added gradually, beginning with preventive care and treatment of children. Perhaps dental teams using paramedicals paid by the sick funds can be introduced during the early years, since the dentists are overburdened and assured of high incomes.

Simplicity and comprehensibility. Many Americans involved in health insurance debates hope for a system in which each provider is paid, regulated, and supported according to his individual conditions, and wherein each community's specific conditions are served. The result is the large number of regulations and disputes, the great amount of uncertainty that critics claim are inherent in government.

National health insurance programs abroad avoid this by employing standard rules applying to everyone. If payment or regulations must be diversified--for example, variations among communities or among types of hospital--broad classifications are employed. Simplicity and predictability are prized, even if some individual providers or communities gain more than a particularized system might give, and even if others gain less. The losses in money and in "justice" are considered smaller than the costs from uncertainty, administrative confusion, arbitrary application of rules, and endless litigation. Providers and the society soon become adjusted to such standardization, if not totally reconciled, since a large-scale public program cannot be administered otherwise. Foreign programs become steadily more standardized--for example, by the elimination of regional differentials in payment of providers.

Bob H

August 26, 1976

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

Dear Stu:

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

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

Cordially,

Bob

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Enclosure

Master for publication

U. S. POLICY TOWARD THE ELDERLY

Anglo-American Conference on the Care of the Elderly

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May 17, 1976

Introduction

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

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

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

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

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

Federal Policy

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

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

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

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

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

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

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

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

Income Programs for the Elderly

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

With all their limitations, Medicare and the income-tested Medicaid programs have done much to equalize the availability of services among the elderly regardless of income. Between 1964 and 1973, the rate of hospitalization increased by almost 40 percent for the elderly poor whi and by 16 percent for the aged who were not poor. The hospitalization rate/ was higher for the not poor in 1964 was higher for the poor in 1973. And in 1964, the elderly poor averaged 6 physicians visits per person per year, as compared with 7.3 for those who were not poor. By 1973, the gap had been decreased to 6.5 for the poor and 6.9 for those who are not poor.

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

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

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

The Chronically Ill and the Very Old

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

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

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

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

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

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

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

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

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

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

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

What of the Future?

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

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

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

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

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

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

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

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

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

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

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

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

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

Conclusion

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

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

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

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

① Stu Eisenstat
② Bob Havely

Bob



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

MEMORANDUM

TO: Madeline MacBean
FROM: Mary King dhsce
SUBJECT: RSC Appearance Before National Association of Neighborhood Health Centers

DATE: August 23, 1976

In your briefing of Mrs. Carter prior to her appearance at the National Association of Neighborhood Health Centers, I thought you might find the following information useful. Words crucial to that audience's lexicon are underlined.

The Neighborhood Health Centers are also called Community Health Centers and number approximately 800 across the country and are of varying size. They represent the first major thrust of Congress toward demonstration that preventive health care, delivery in an ambulatory setting in the patient's neighborhood, could reduce the need for hospitalization and improve a family's health.

Most of them are federally funded and either the 1966 Partnership for Health Amendments to the Public Health Service Act or the 1967 so-called Kennedy Amendments to the Equal Opportunity Act (that basic act set up the Johnson poverty program). Under the PHS legislation they were administered in HEW. Under the latter legistation, they were administered by OEO. Had Congress thought HEW was doing its job well, it would never have set up this program in OEO. But the needs of the poor as a group had not been the subject of special focus in HEW. At any rate, they operated under the only federal mandate for demonstration of health services delivery (most of the federal role in health is financing, not services delivery). They are all under HEW now.

Their basic concept calls for health services to be delivered in pleasant surroundings in the neighborhood so that families will properly utilize health care and the need for hospitalization will be reduced. The hope is that old patterns of seeking care at the hospital Emergency Room like Grady -- when the patient is spitting up blood or is too ill to work -- and long after preventive care might have helped, will be broken. Families are treated as families and there is an attempt to intervene in the nutrition and living patterns of the family which might be causing ill health of one of its members. Family health workers are local neighborhood people

trained as entry-level health workers. They go into homes of the patients registered at the health center and try to intercept problems before they arise. Most of the centers stress consumer involvement in certain policies such as hours of service, priorities in expensive dental services and community sensitivity in staff.

Comprehensive services and team delivery are also important to the concept. All ambulatory services required for primary care are housed under one roof, and an internist, pediatrician, nurse and social worker generally work as a team. Every attempt is made ot integrate mental health services as a part of the primary care approach. (Primary care is originally a British concept designating the first level of direct care needed to help the patient. It does not include speciality care like surgery or tertiary care -- super-speciality care -- like neuro-surgery. Primary care is a touchstone of the neighborhood health center concept.)

It costs an average $157 a year for each active patient in a neighborhood health center, covering an average of four and a half visits per year. The Association now produces data substantiated by HEW that shows it is indeed less expensive in the long run to deliver care in this way. From the human standpoint, there should never be any argument of effectiveness, but the Nixon Administration slashed this program ruthlessly, using the charge that it was too expensive as justification.

This form of services delivery will be ideal under National Health Insurance because it will cut down on much of the wastage of private fee-for-service care as well as hospitalization. Some of the centers operate in the manner of Health Maintenance Organizations (HMO's) with group reimbursement for services from Medicaid rather than individual reimbursement.

The two biggest problems of these health centers have been:

a) Because the basic enabling legislation was under OEO, and eligibility required that you be poor, these experimental programs were developed in a social and political milieu which had many problems unrelated to health. The program concept has been shown to be sound and workable but these programs were and still are burdened by the additional problems of being developed solely in poverty areas. For example, old untreated conditions surface when you start to deliver services in a poverty area that will inevitably make the costs higher than they would be in a middle class area.

b) Because of the constant cutbacks in their funding, the centers have trimmed many social services away. This severely limits effectiv eness in grappling with such problems as aging, retardation and disabilities which are not "health" as such.

Bibliography: - ① will send bibliography -
② Pair of Obesity. ; Book -

8/19.

- Problems:

(Has interest in develop Institute of health - etc at Penna.)

① Problems of Control of Lives

② Establishment & Scientist may object

See his types Note

③ Is evidence allin?

④

ADVantage - See his notes

He in for N.H.I. - for personal input + Cut health Expenditures.

② - Polit importance in emphasizing Medicare Medicaid to not prevent this split

③ - Tobacco lobby. - Ferry - & Pres. Johnson agreed they " " would not undercut but not Support.)

④ - For profit org discipline - do not necessarily need-free publicity - VS. potential voter

People Consulted by Dr. Stinnard - (on Govt Health & Drug Reform Line)

① Phil Lee. - in July

② Ann Somers - Prof. of Health Economics
N.J. College of Med. & Dentistry
Rut

③ Olcott Smith - Pres. (or Chairman Bd.)
Aetna Life Ins.
Hartford. Conn.

④ Samuel Karter - Director of Lennard Davis
Inst. of Health Eco.
Treas. of Rensa.

⑤ 8 or 9 Members of Faculty + Dept Heads (Psychiatry + Int. Medicine) of U. of Pa. Med. including Larry Klein yet | Criticized early versions.

⑥ Doug Carter - Helped with outline.

⑦ Luther Terry. - Former Surgeon General of U.S. - Dir. Am Phila - as Consultant. (Johnson appointee)

Dr S. would like to meet & discuss with
① John Knowles, MD.
② Ted Cooper MD.
③ Julie Richmond - who - is good friend.

Used Johnson alarm price hope 26

MONTEFIORE HOSPITAL AND MEDICAL CENTER

111 EAST 210TH STREET, BRONX NEW YORK 10467

OFFICE OF THE DIRECTOR

Telephone:
Area Code 212

September 7, 1976

Ms. Mary King
Carter Campaign
P.O. Box 1976
Atlanta, Georgia 30301

ATTENTION: DOMESTIC DEBATE--HEALTH ISSUES

Dear Mary:

In addition to the revised memorandum on health manpower, preventive medicine and family health that you will be receiving this week, I thought that a briefer political analysis of several of the major points might be helpful in preparation for the domestic policy debate on September 23. I think the following points could be made and should be watched for:

1. Adequate financing for Ambulatory Care and Preventive Services is essential. Changes in the delivery system will not occur without concomitant changes in financing. Lower reimbursement rates for rural areas must be corrected and equalized with urban and suburban areas. Financial incentives must be provided to insure that basic preventive services such as immunizations and effective screening tests (hypertension, cervical cancer, etc.) are provided to all Americans and that the most efficient provider is reimbursed for providing them. This could certainly be proposed as one of the first "phases" of any health insurance proposal.

2. Public and Consumer Education in Preventive Medicine and Health Promotion. There has been no effective federal leadership in this area and a good political point can be made of this. The only HEW activities

of any generic significance (there are a few notable categorical exceptions like the National High Blood Pressure Education Program) are an ineffective Interdepartmental Panel on Health Education chaired by the Assistant Secretary for Health and a small Bureau of Health Education located in the CDC which has a very small budget (about $3 million) and no concerted major thrust.

The National Health Information and Promotion Act, recently passed by Congress, was opposed by the administration but signed anyway because of its inclusion in the overall CDC renewal and because of the likelihood of an override. It calls for significant sums of money for community demonstrations, research projects, and information programs relating to health promotion and prevention. It would also require the establishment of an office of Health Information and Promotion in HEW to develop the area as a major thrust. The administration appears to be doing only the minimum required by law: no additional funds have been requested as a FY '77 supplemental budget; the required office will be staffed by two professionals, and it appears to be business as usual with the focus still in the Bureau of Health Education at CDC. I think a political point could safely and effectively be made here--you might want to talk with Anne Somers, who is very much on top of it.

3. Health Manpower. In general this area is somewhat tricky politically since the administration has made some good efforts here and also the new bill, which is a Democratic effort of Paul Rogers and Ted

Kennedy, will probably be sent to the President for signature within the next several weeks. It probably will NOT be sent to the White House in time to force a signature or a veto prior to the debate. My guess is that Ford will sign it in any case, so some of the political advantage is lost. There are a number of manpower points, however, that can be made, which I think the candidate is concerned about and which have been failings of the administration--and in some cases, not emphasized enough in the bill as reported from conference.

a. Total Physician Supply and Foreign Medical Graduates. Whereas the administration has recently correctly argued that the total number of physicians is adequate, they have been opposed to addressing the issue of foreign medical graduates aggressively, even though between 40-50% of all new licenses each year are given to foreign graduates; even though the examinations for FMG licensure are considerably less stringent than for domestic graduates; and even though most Americans are concerned about the problem. The administration's position has been only that the examinations should be made similar. They have consciously chosen not to highlight the moral and ethical international "brain drain" effect. The conference bill contains provisions that begin to address this issue, although "brain drain" has not been emphasized, nor have physicians been eliminated from occupational immigration preference categories--a provision favored by Kennedy but eliminated by administration senators (Beall) in Senate markup. The overall posture should be that within the total supply the FMG component

should be significantly reduced for reasons of quality and brain drain and that any deficit should be made up by more American graduates trained with an emphasis on primary care, prevention, and service to rural and inner city areas. Obviously this should all be done in a way that does not discriminate arbitrarily against the FMG of quality who is not needed by his own country.

b. Geographic Maldistribution of Health Personnel. The Ford/Nixon administration has been relatively successful in the initiation of the National Health Service Corps and has supported a moderate expansion in the scholarship program that obligates students for such service. Some curriculum reform has also been initiated. What has been absolutely lacking, and is lacking in any significant way in the new manpower bill, is a major thrust to change admissions standards in schools of medicine and dentistry to focus on a percentage of individuals whose rural or inner city background, lower socioeconomic status, and personality make it probable that they naturally want to do "general practice" in underserved areas, rather than having to be obligated to do so. Most admissions committees choose candidates like themselves--urban specialists; but in a very few schools, aggressive efforts have begun to work. A Carter administration should stimulate and finance such further efforts as a national priority in health.

c. Minority representation in health professions schools. During the Ford/Nixon administration, the percentage of ethnic minorities in medical schools has not only fallen short of the goals, but has

been slipping backward. Out of a total health manpower budget of $600 million in FY '75, only $15 million was devoted to this problem. Many of the programs funded were "refresher" courses that are simply too simple a solution to a very complex problem. The answer is early college identification of minority students who are highly likely to succeed in a health profession and provision to them of financial support, counselling and careful preparation and follow-up both in college and in professional schools.

d. Excess Physician Specialists. This is a very complex problem that has been the major problem area in getting a new health manpower bill over the last three years. The administration favors a national study commission plus more support for family practice and general pediatrics and general internal medicine, which are good. The new manpower bill also requires medical schools that receive capitation payments to guarantee that the residency programs affiliated with them train a certain percentage of generalists. This is also appropriate, but somewhat cumbersome since the schools have little direct control over what the hospitals do. The most effective approach would be to fix national targets for numbers in each specialty, exert strong influence on those in oversupply to keep constant or cut back, and make funds available to teaching hospitals to make sure that the new positions required by the coming increase in total physicians are established primarily in the general categories. Much less support would be required for this purpose if the health insurance program supported primary care ambulatory services.

4. Health Services Research and Health Care Managers and Planners.

With costs of health care being out of control, very little attention is being paid to developing new methods of health care delivery and management that will help cut costs and improve quality. More resources and a new direction and thrust for these areas are essential and not that expensive. At the same time, there are not enough managers and planners with specific skills to help guide the system to cut costs and improve services. Programs in schools of public health and health care administration must be quantitatively and qualitatively increased.

5. Health Care as an Integral Part of Strengthening the Family Unit.

Other factors such as employment and education are obviously more important than health in this area. A number of health-related points can clearly contribute to this thrust however.

a. Increased production of family-oriented physicians, nurses and social workers who can provide a single integrated locus of care for the interrelated health needs of the whole family.

b. Increased use of supportive persons and services such as homemakers and visiting nurses to help families to cope with longterm illnesses and disabilities to keep the family together and reduce institutionalization.

c. Teaching and permitting family members who are available to provide appropriate parts of institutional care, e.g., feeding and simple nursing in the hospital.

d. Training of health professionals in psychosocial problems of families.

e. Increased availability and utilization of family planning techniques

as well as amniocentesis.

f. Public education in schools regarding basic preventive medicine and health promotion for the family, as well as responsibilities and realities of being a spouse, a parent and a child.

I hope these notes are helpful. Please let me know if anything else is required.

Sincerely,

Dave

David A. Kindig, M.D.
Director

DAK:cb

cc: Stuart Eisenstadt
Jack Watson
Ruth Hanft

MONTEFIORE HOSPITAL AND MEDICAL CENTER
111 EAST 210TH STREET, BRONX, NEW YORK 10467

OFFICE OF THE DIRECTOR

Telephone:
Area Code 212

September 7, 1976

Governor Jimmy Carter
Plains, Georgia

Dear Governor Carter:

Thank you for your note of August 23. I was honored to be asked to offer advice to you on national health issues and pleased that it was helpful. I have submitted to Mary King some follow-up material from a more political perspective that may be useful in your preparations for the domestic policy debate.

The hopes of many health professionals (including physicians!) concerned about equal access to good health care for all Americans will be with you in the coming months.

Sincerely,

David A. Kindig, M.D.
Director

DAK:cb

bc: Mary King

MONTEFIORE HOSPITAL AND MEDICAL CENTER

111 EAST 210TH STREET, BRONX NEW YORK 10467

OFFICE OF THE DIRECTOR

Telephone:
Area Code 212

September 7, 1976

Lester Breslow, M.D., M.P.H.
Dean
School of Public Health
The Center for Health Sciences
University of California, Los Angeles
Los Angeles, California 90024

Dear Dean Breslow:

Thank you for your note of August 24. I would have written you sooner, but I left on vacation immediately following my trip to Georgia.

I received the materials that you forwarded with great interest, particularly the draft on the Lifetime Health Monitoring Program and the summary of the preventive medicine conference. I thought the latter contained the most thoughtful statement of the purpose of preventive medicine from a philosophical point of view that I have ever seen.

The briefing dealt mainly with welfare and education although a number of general points were made regarding health services and health financing. There seemed to be a good familiarity with, and commitment to the importance of preventive medicine and health promotion, both in terms of specific delivery and public education .

It is my impression that specific option proposals in the area for implementation with pros and cons of each would be most helpful at this point and should be forwarded to Mary King or Stuart Eisenstadt at their Atlanta headquarters.

I would be most interested in sitting down to exchange ideas the next time you are in New York.

Sincerely,

David A. Kindig, M.D.
Director

DAK:cb

bc: Mary King

July 26, 1976

Jacob K. Javits, U.S.S.
United States Senate
Washington, D.C. 20510

Dear Senator Javits:

I am pleased to respond to your letter of 14 July 1976 inviting comment on your bills to establish a system of national health insurance for mothers and children and to provide for comprehensive maternal and child health care practices.

These bills have many desirable features. As a long-time advocate of a comprehensive national health insurance program for the entire population, I have from time to time wondered whether it might be desirable to proceed next with coverage for mothers and children as you propose.

At present, however, I favor proceeding directly with the Health Security Program for all persons. The reasons are many but this is not the place for them since you want comments on your own bills.

My comments follow:

Sec. 2. (a) (3) not the greatest but great potential; other factors I believe are even more important for improving the health status of the general population.

Sec. 2 (b) (2) and (3) Emphasis on prevention and efficiency is excellent.

Sec. 102 (a) (1) and (2) Excludes pregnant wives and children of illegal aliens. Until our immigration policies are straightened out, this provision would in effect require local taxpayers, e.g. in Southern California, to pay substantial sums for medical care for prospective native-born Americans and de facto Americans.

Sec. 111 (a) I doubt the wisdom of full-time Board administration; personally I favor a single, strong executive with a part-time (but substantially committed) Board to adopt regulations. That brings a Board membership directly from the people, not one immediately co-opted into the Federal machinery. If the pattern of administration I favor is adopted, responsibility of the Executive Officer is clear and the Board and Advisory Council functions could be consolidated into one body.

Sec. 202 (2) and (3) Define "qualified" pediatric and obstetric units without specifying anything about the professional direction or staffing thereof. That is a serious omission. The Section should at least require the Board to establish standards for professional direction and staffing of such units. Quantitative standards are not enough.

Sec. 203 (a) and (b) Delegation to State agencies would be desirable under some, perhaps most, circumstances. Delegation to private agencies, even JCAH, is not in my opinion justifiable on the basis of Medicare experience. Such private agencies remain too much under the effective control of providers, thus creating an inevitable conflict of interest. Such private agencies can play a highly effective role in pushing standards ahead of the governments, where they are able to do so, and in advising government.

Sec. 211 (b) 3. A surgeon should be permitted to participate if certified or if eligible only within five years of becoming eligible. Unfortunately some become eligible and then begin to deteriorate, never becoming certified; they can be dangerous to your health.

Sec. 211 (b) 4 and 5 Second consultations as indicated are excellent. The Administration will have to watch the pattern of these "second consultations".

Sec. 212 (2) Refers to (c)?

Sec. 218 (b) and Sec. 225 (b) Permit the Board to exclude certain items if they are unsatisfactory. It would be excellent to extend such authority explicitly covering all providers of service under the Act. That would be a highly important feature of quality control.

Sec. 303 (a) Permitting such contracts with private carriers will, in my opinion, lead to no end of trouble. Experience with them in Medicare has been very unsatisfactory. I refer you to Senate and GAO investigations.

Sec. 305 (b) Co-payment, even a "small" amount, probably deters preventive services, e.g. for pregnant women. The cost of administration, confusion and ill-will generated will readily overwhelm any "savings" or "benefit". Why not apply it to a hospital as much as to a physician's office? Why have it at all?

Sec. 603 Confusing to me, probably on basis of misunderstanding.

In general I would say that you have incorporated several desirable features.

On the other hand, I would advance three general criticisms:

(1) Confusion at this time with the move toward a Health Security Program.

(2) Failure to maintain some very desirable features of the Health Security Program, especially no contracting out with private carriers.

(3) Failure to define adequately or provide for the definition of preventive services, in general and particularly in relation to the groups of physicians. It is now technically possible and highly desirable to be very specific about this matter. Leaders in the field have reached a consensus as to what should be included.

Thank you for the opportunity to comment.

With best wishes,

Sincerely yours,

Lester Breslow, M.D., M.P.H.
Dean

LB:b87

cc: Senator Alan Cranston

Stu's Assistant Director
(202) 857-1614
M & Stu

Bob Havely,

Both Stu and I had put in to the scheduling operation a request for a major speech on Preventive Approaches to Health Care for the American Public Health Association on October 18, as I know you recall.

Assuming this is still to be scheduled, enclosed is all the material I "commissioned" for a preliminary draft.

We can go directly from these materials to speech form if one of the staff working with Pat Anderson is ready. Or we can go to a substantive memo to go simultaneously to the Governor and Pat from Stu and me. The latter is the approach Stu said he wnated earlier.

Could you check the status of scheduling or whether Stu knows more? I too plan to check with scheduling. Also, I think a memo as Stu suggested is the best approach but don't have the time to do it for the next two weeks.

How shall we proceed?

Doug

September 13th

UNIVERSITY of PENNSYLVANIA

PHILADELPHIA 19104

ALBERT J. STUNKARD, M.D.
Visiting Professor
Institute of Neurological Sciences

Please Reply to:
415 Stouffer Building
Philadelphia General Hospital
700 Civic Center Blvd.
Philadelphia, Pa. 19104

August 18,1976

Dear Mrs. Eisenman,

I am attaching a copy of the paper on "Our Health and the Way we Live" which I have prepared for Governor Carter for possible use in his campaign.

I will be glad to meet with you and/or Mary King to discuss the various aspects of this paper and of this issue, at your convenience.

Sincerely,

Albert Stunkard

Albert Stunkard M.D.

Add homicides

OUR HEALTH AND THE WAY WE LIVE

A Talk Prepared for Governor Jimmie Carter

by
Albert Stunkard M.D.
Visiting Professor
Institute of Neurological Sciences
University of Pennsylvania

OUR HEALTH AND THE WAY WE LIVE

This evening I would like to talk to you about one of the most important of our national concerns: the health of our people. Health is a precious national resource and in pursuit of better health we as a nation have invested vast amounts of money and an increasing proportion of our gross national product. The bill for health services has increased from 26 billion dollars in 1960 to 118.5 billion dollars last year. We have built the finest medical research to be found any place in the world and a huge medical care system comprising 7,000 hospitals and employing 4.5 million people.

Our Poor Record in Health

What are the results of this vast investment? How good is the health of American people? The answer is: not good enough. When we compare our health record with that of other industrialized nations we find ours is sadly lacking. One indicator of the health of a nation is its life expectancy. Six nations have a longer life expectancy for women than we do. Infant mortality rate is another indicator of a nation's health. We rank no better than 15th in the world in infant mortality. And in life expectancy for men, we rank 19th. These figures are disheartening enough, but they are not all. For this burden of disease and death is not evenly distributed among our people. It falls most heavily upon the poor and disadvantaged. A black

child born in the United States today has twice the chance of dying in infancy that a white child does.

What are the reasons for these failings? Why hasn't our huge investment of effort and money brought us better health? And, most importantly, what can we do about it?

A large part of our problem is that we have shirked the responsibility of looking after our own health. We have tried to shift that responsibility to the medical care system. And we have neglected doing the things that we can do for ourselves.

And a large part of the answer will be for us to take more responsibility for our own health. What we do and don't do to ourselves can improve our health far more than could even vast additional expenditures for medical care.

For most of the pain and disability and death from which we suffer is a result of diseases that we can treat imperfectly. We can, however, prevent some of these diseases from occurring at all and we can delay the occurrence of others. And as President Kennedy pointed out several years ago, prevention is far more economical and far more likely to be successful.

How Can We Prevent Illness?

The key to prevention lies in the causes of disability and death which afflict us. For a vast amount of our ill health today is caused by the way we live--by the environment which we have made and by the personal habits and life styles which we have adopted. But if our health is impaired by the way we live, it can be improved by changing the way we live.

The Toll of Accidents Among Young Americans

Let us look at the leading causes of death among two age groups in our population: the young and the old. Among the young people of our nation far and away the leading cause of death and disability is accidents, particularly motor vehicle accidents. 45,000 people died on our highways alone last year and 2 million people were seriously injured in motor vehicle accidents. Three times as many young people die in accidents as in ~~any of~~ the next ~~three~~ two causes of death. And ~~two of them are also~~ they are also violent deaths: suicide and homicide. Thus, the three ~~of the~~ leading causes of death among the young are due to personal habits--to the way we live. But this also means that they can be reduced by changing the way we live, ~~by changing our personal habits~~.

Now there are pessimists who argue that it is a tragedy for so many young people to die these violent deaths, but that there isn't anything that can be done about it. Aren't accidents, for example, due to careless driving or to circumstances beyond our control? And what can be done about that?

Well, a lot has been done, and a lot more can be done. When the speed limit was lowered to 55 miles per hour, deaths from motor vehicle accidents were also lowered--from 55,000 to 45,000--and so was the injury ~~rate~~ number of injured and maimed and crippled and so were the costs of their medical care, ~~of accident victims~~. And we could save 10,000 more lives if all of us wore seat belts instead of the one-fifth who do now. And we could save 10,000 more lives on top of that if we

stopped driving after we had been drinking. For half of all deaths on the highway are alcohol-related. I believe that we can cut down this terrible toll and I propose that we proceed to do just that.

The Toll of Heart Disease Among Older Americans

Now, what about older Americans? Personal habits and life style lie at the root of the causes of death of older Americans just as surely as they lie at the root of the violent deaths of young Americans. Today over a third of all deaths in our country are due to heart disease, primarily coronary heart disease which has reached epidemic proportions among middle-aged men. Yet most of the known causes of coronary heart disease are a result of our personal habits. First, there is overeating. Overeating and overweight contribute to coronary heart disease directly and also indirectly, by increasing the likelihood of diabetes and high blood pressure and by increasing the severity of these diseases.

Second, there is smoking, which has its effect upon the heart just as surely as it does on the lungs.

Third, there is inactivity and lack of physical fitness. One-half of our population does not engage in any kind of regular physical exercise.

There is high blood pressure with its ill effects upon the heart.

Finally, there is the lack of knowledge about heart attacks that leads people to delay seeking medical help until it is too

late. Half of all victims of heart attacks die before they reach the hospital.

Now, ~~there are~~ once again the pessimists ~~who~~ will ~~say~~ tell us that there isn't anything that can be done about all this. They will say that there have always been people who eat too much and smoke too much and exercise too little and don't take their medicines--that there always have been such people and there always will be.

Well, the facts are that people <u>have</u> been changing these habits and the rate of coronary heart disease <u>has</u> been going down--10 percent in the last few years. We do not know of all of the reasons for this decline, but we believe that a good part of it is due to modification of the risk factors I have just described.

This is a good start, but it is <u>just</u> a start. Our rate of coronary heart disease is still second highest in the world--twice that of some European countries and almost ten times that of the Japanese. And I cannot forget that we rank 19th among the nations of the world in life expectancy for men. We cannot rest until this indictment is erased.

Many of our tasks are already under way. The National Institues of Health have launched large-scale clinical trials which should teach us more about how changing our personal habits can enhance our health. But the major effort in changing these habits is up to us. How well are we doing, and what more must we do?

<u>Weight Reduction</u>

More and more people are becoming aware of the advantages of weight reduction and of moderation in eating and they are acting

on this information. The average weight of women in the United States has begun to decline, and this is just the beginning. And new treatments are being developed to help people control their eating which are more effective than the old ones. We must encourage research to make them even more effective and we must make them available to everyone who wants to lose weight.

Control of Smoking

What about smoking? A growing number of middle-aged men, a group with a very high rate of coronary heart disease, has taken to heart the warnings about smoking. And the number of middle-aged men who smoke has decreased by over 10 percent in the past few years, even during a time when the overall rate of smoking was increasing.

But it is hard to stop smoking. We should provide assistance to everyone who wants to stop. Here, too, new methods of treatment are being developed. We should assist efforts to improve them and to make them more widely available.

We should encourage the tobacco industry in its commendable efforts to reduce the tar and nicotine content of cigarettes.

Exercise and Physical Fitness

We are making headway in dealing with the problems of inactivity and lack of physical fitness. Physical exercise and recreation are attracting more and more people. The number who are taking up tennis and swimming is increasing and we see more

and more joggers in the streets and back packers in the countryside. But we must do more.

All too many people just don't have the facilities for physical exercise, even when they want to be more active. Yet our country abounds in indoor and outdoor recreation areas and most of them are far from fully utilized. Our schools and colleges have athletic fields, gymnasiums and swimming pools which could be made available to the neighboring community. We must help see to it that every American who wants to take part in physical activity should have the opportunity. And we must help organizations such as the President's Council on Physical Fitness to help people to see the value of physical exercise and physical fitness.

Control of High Blood Pressure

The prospects for the control of high blood pressure have never looked brighter. For new treatments have given us the possibility of greatly improving the control of this disease. The major problem right now is an educational one. Only three years ago in this country, half of all the people with high blood pressure did not know that they were suffering from the condition. Of the half we knew, half were not receiving any treatment for it. Of the half who were receiving treatment, only half were receiving adequate treatment. Thus, only 16 percent of people with high blood pressure were receiving adequate

treatment for it. Yet this treatment is safe and effective and it can greatly reduce the complications of this disease. Here lies a great potential for improving our health.

In just the last three years the National High Blood Pressure Education Program of the Department of Health and Welfare has made an excellent start in bringing these facts to the American people. Today the percent of people with high blood pressure who are receiving adequate treatment has risen from 16 percent three years ago to 29 percent today. But 29 percent is far too low; these programs must be encouraged and expanded. We must make it possible for every American to have his blood pressure tested. And we must see to it that those who need treatment for high blood pressure can receive adequate and effective treatment.

I have discussed with you just two of the major health hazards that arise in part from our life styles and personal habits. Accidents and heart disease are the leading causes of death among our young and our old. But there are many other ways in which our health is impaired by the way we live and many other ways in which it can be improved by changing the way we live.

There is the terrible death toll from cancer of the lung, which could be cut to a fraction of its present size by smoking cessation. There is the plague of alcoholism which afflicts 9 million people in this country, and which costs $15 billion a year. There is the distressingly high number of people with no teeth or badly diseased teeth--problems which can be almost eliminated by proper dental care by each individual.

For too long we have tolerated this erosion of our nation's health. We have excused it by saying that there was nothing that we could do about the personal habits that lead to disease. But we can no longer use that excuse. We know that we can change these habits.

Then we have used the excuse that abusing our health is a personal choice that doesn't matter to anyone else. So we have continued to eat too much and drink too much and smoke too much and drive our cars recklessly and justified it all in the name of personal freedom. But one person's freedom to abuse his health is every other person's bondage in higher taxes and larger insurance premiums and escalating medical costs. The health of every American affects every other American.

But what do we do about it. Well, we could give up. There are always voices that tell us there is nothing that we can do about our health. Some medical scientists take this view. Others disagree. We can find scientists on both sides of questions such as: does overeating and overweight contribute to sickness and death? does exercise diminish the severity of coronary heart disease? do foods high in fat and cholesterol increase the likelihood of coronary heart disease? Faced with conflicting opinions from the scientists, it would be easy for us all to sit on our hands. It certainly makes it easy for those who abuse their health to find so-called scientific excuses.

But many of our health problems are so pressing that I believe we cannot afford to wait until all the scientific evidence is in. We must take action now. We must ask the scientific community to make special efforts to resolve the remaining questions about our health and the way we live. And we must use this new information to make our programs more effective. But we must start work on these programs now.

Others despair of our trying to improve our own health because they think the responsibility for health can be shifted to the medical care system and the government. Too many of us have developed an unreasonably high expectation of our health care system and we have become far too dependent upon it. We do not see why we should do what we can to preserve our own health. We put all that responsibility on what seems to be our all-powerful system of medical care and expect that it will pick up the pieces when anything goes wrong.

Yet if one thing has become clear in the past few years, it is the limitations of our medical care system. For most Americans medical care is not the only or even the most promising route to better health. For a long time now we have been developing expensive high-technology solutions for problems that arise from the way we live. Yet changes in the way we live--in our eating, smoking, drinking, and exercise--would do more for our health than a doubling of the expenditures for medical care.

But is it a proper function of the government to involve itself in such matters? Clearly the government must not intrude into people's lives to change their lifestyles, just as it should never do for people things that they can do for themselves. But it is a proper function of government to help people to help themselves and to help them take responsibility for their own health. And this is the course I propose.

A Three-fold Program

What should be the role of government in helping people to help themselves? First, we must change the current system of incentives to encourage people and their doctors to prevent illness in addition to treating it when it appears. Second, we should provide assistance to the health education efforts that are now being carried out and third, we should provide support to the many voluntary health efforts which are already being made to improve the nation's health.

Changing the Incentives for Health Care.

Let us take up these three programs one by one. We must move at once to change the incentives of our current health care system. We must change our current system of disease insurance into a system of true health insurance.

For now the hospital is paid only for treating the sick. The physician is paid only for treating the sick. The individual gets very few rewards for leading a healthy life. And the leading culprit in perpetuating this out-moded system of disease insurance is our federal government. The confusion of the present administration is nowhere better illustrated than in the conflicting voices with which it speaks on health policy. On the other hand, it proclaims--and rightly in my opinion--that prevention of illness is its highest priority for health. On the other hand it implements this fine rhetoric by massive financial support of a Medicare system which specifically forbids reinforcement for prevention of illness and of a Medicaid system which discourages such reimbursement.

This shameful situation must be changed. There is no reason in the world why we cannot provide incentives for people to take more responsibility for their own health. There is no reason why we cannot provide incentives

to the health professions to encourage their clients to live more healthy lives. There is no reason why we cannot provide incentives to industry for innovative programs of health promotion for its employees and to unions for improving the health of their members. There is no reason, in short, why we cannot invest a small fraction of our vast bill for medical care to keep our people healthy, as well as to treat them after they have become sick.

For a long time now insurance companies have found that it is good business to reduce the costs of automobile insurance for young people who take driver education courses. Surely such incentives can be provided just as easily to people who have taken measures to improve their health. And the government does not need to leave this matter to the insurance companies. Tax deductions as well as insurance deductions could go a long way towards encouraging healthier behavior. For example, individuals could be provided with a tax credit and an insurance deduction for taking courses to stop the really hard-to-change habits--smoking and overeating and abusing alcohol. They could obtain still larger benefits for actually changing these habits: reducing their weight and their blood pressure and stopping smoking. And even more effective than incentives for individuals could be incentives for groups; encouraging the staff of an office or the members of a union to collaborate in the rewarding enterprise of improving their health.

One of the attractive things about incentives is that they don't have to cost a great deal of money. More important than the actual dollar value of an incentive is the knowledge that someone in a position to make a

difference cares about us. This psychological leverage means that even small incentives can make large differences in peoples' behavior and that incentives to adopt healthier lifestyles and personal habits can be offered on a sound financial basis.

I am happy to report to you that some insurance companies have already taken the first steps in changing incentives from simply treating illness to preventing it before it occurs. We will be watching with great interest the pioneering Blue Cross programs of cancer detection and prevention of alcoholism and the imaginative efforts of the Massachusetts Mutual Life Insurance Company to lower insurance premiums for people who stop smoking. We must encourage these programs and extend them as they prove their worth. And we must not rest in these endeavors until it is as profitable for people to stay well--and for our health care system to keep them well-as it is for them to be taken care of once they have become sick.

Health Education

The second major means of improving our health is through health education. There are basically two kinds of health education: the traditional education in facts and the newer education in skills. Both are important.

All too many Americans today do not know some of the basic facts about their health. The fact that half of all Americans with high blood pressure did not know that they were suffering from this disease speaks volumes about the need for better health education. So do the figures on teen-age smoking. During one recent six-year period, for example, the number of teen-age girls

who started smoking doubled--from 10 to 20 percent. It is hard to believe that this could have occurred in the face of effective health education in the classroom. For although health education has been shamefully neglected in our nation, there have been some notable successes. Not all of us can reel off the seven danger signals of cancer that have been publicized by the American Cancer Society. But the publicity about these danger signals has saved the lives of many people who took them to heart and sought out early diagnosis and treatment for cancer. Similarly, the American Heart Associations campaign to publicize the symptoms of heart attack has encouraged people to seek treatment earlier in the course of their heart attacks, and has saved their lives in the process.

For many people, learning the facts of health and disease is enough to persuade them to develop healthier habits. But for others, just knowing the facts is not enough. They know that they would be better off if they did not overeat, smoke, abuse alcohol. But they can't seem to do much about it. These people require the kind of help that is provided by the newer developments in health education-help in learning the skills necessary to change unhealthy habits.

Teaching the skills of healthy living is not an entirely new development. For many years Alcoholics Anonymous has taught its members how to change their alcoholic lifestyles and to abandon old patterns of drunkenness for more successful methods of coping with life's stresses. What is new, however, is the use of systematic, step-by-step training in exactly how to change unhealthy habits, and continuing research and development to make this training more effective. This approach is being more and more widely used in the control of overeating and it has been far more successful in helping

people to lose weight than the old methods of simply handing out a diet. It gives every promise of becoming more effective and of being applied to more and more health habits.

Enlisting the American People

How do we go about helping people to learn the facts and skills of healthier living? As a start, the federal government can begin to provide some of the leadership which has been so badly lacking in recent years. One valuable means is through the Office of Health Information and Health Promotion. This Office which owes so much to the untiring efforts of Senator Kennedy and Congressman Rogers was established on June 23rd of this year. It can serve as an invaluable center for government efforts in health education and it deserves our strongest support.

But, just as war has become too important to leave to the generals, health is too important to leave to the government. The government must encourage and support efforts at health education and health promotion. But these efforts have always come best from the people. Let me pay tribute to just a few of the many voluntary organizations which have made notable contributions to the health of the American people in the past, and which can form the basis for a broad-scale program of improved health for our nation.

First and foremost I count our schools. The 45 million children in our elementary schools deserve the same kind of high quality education about their health that we strive to give them in traditional subjects. The personal health habits which they develop as children will determine whether their self-imposed risks of illness in later life will be large or

small. There are two million teachers in the schools of our country. With only a very small increase in their own education they can be prepared to instill in their pupils the healthy habits and lifestyles which will stand them in good stead throughout their lives.

We are fortunate to have in the United States today a large network of voluntary agencies with a proven record of helping people to reduce the risks to their health. We must pay tribute to Alcoholics Anonymous for their outstanding record of help for alcoholics and their families. More recently a growing list of voluntary associations is helping people to control their overeating and their weight. Two million people attend Weight Watchers meetings each week, a far larger number than receive medical treatment for their weight. TOPS (Take Off Pounds Sensibly), Overeaters Anonymous, and Diet Workshop help many other overweight people and a growing number of similar self-help groups are helping people deal with other habits which pose risks to their health. We must recognize these organizations and we must help them to improve and extend their services.

Other services are rendered by the many voluntary health agencies that have been organized to support public education and research into a number of critical illnesses. The American Cancer Society and the American Heart Association and their many local branches are just two of these organizations which are doing so much to improve health. They, too, must be recognized and their efforts encouraged and supported.

Our fraternal organizations have a long and distinguished record of voluntary and private support for health. The Shriners with their hospitals for crippled children and the Lions with their support for the treatment of eye diseases are but two of these organizations which deserve recognition for their efforts in the past and help in their work in the future.

Many of our Churches have been leaders in helping people develop more healthy personal habits. The Mormons are renowned for the excellent health of their members and the Seventh Day Adventists have established an admirable record for helping those who wish to stop smoking. Our churches are a major resource for improving the health of the American people. We must recognize and foster their efforts.

Our youth groups have long been in the forefront of those seeking to improve the physical fitness of the nation. The Boy Scouts, the Girl Scouts, the Four-H clubs, the Future Farmers of America and many other worthy organizations must be recognized for their outstanding work and given the assistance they need to extend it.

Our unions have been pioneers in improving the medical care of their members, from the model hospitals of the United Mine Workers to the comprehensive insurance plans of the United Auto Workers. A small fraction of these efforts devoted to improving health-related habits could produce just as impressive benefits. Similarly, industry has begun to develop programs for employees with problems such as alcoholism, carried out on time released from work. Such programs have proved to be good business for the company. They are also good news for our country and they should be encouraged and expanded.

Two of our industries have a particularly important part to play in improving the nation's health. Madison Avenue is known today as a symbol of the power of our communications and advertising industries to change the buying habits of the American people. Surely this power can be used to change the health habits of the American people. Let us enlist these two great industries in a concentrated, systematic program of health education and health promotion, on television and radio, in newspapers

and magazines, utilizing all of the powerful techniques that have been developed to market products, for the marketing of improved health for the American people.

The food industry is an important ally in the effort to improve the national health. This industry has made great strides in preparing more nutritious foods and has pioneered in developing new foods with lowered cholesterol and fat content for people in danger of coronary heat disease. Similarly, the food industry has made great strides in labelling the nutritional content of foods, an essential step in enabling people to choose healthy foods. These efforts must be encouraged and extended. And we must bring the restaurant industry into these efforts to identify the nutritional content of the food which it serves, and to make avilable more nutritious foods, particularly foods which are more healthy for the heart.

NATIONAL ORGANIZATION FOR THE REFORM OF MARIJUANA LAWS

NORML MEMO

2317 M STREET, N.W., WASHINGTON, D.C. 20037/202-223-3170

TO: DR. PETER BOURNE

RE: GOVERNOR CARTER'S SUPPORT FOR MARIJUANA DECRIMINALIZATION

FROM: KEITH STROUP
NATIONAL DIRECTOR, NORML

DATE: SEPTEMBER 10, 1976

In anticipation of possible Republican criticism concerning Gov. Carter's endorsement of the concept of decriminalizing minor marijuana offenses, I want to suggest a number of responses which might be appropriate should this arise. It is important that Gov. Carter and the members of his family be prepared to respond in a positive manner, rather than gradually back-tracking until the substantive position of decriminalization has been completely lost.

1. The concept of decriminalizing marijuana has been endorsed by the National Commission on Marijuana and Drug Abuse (March, 1972), the American Bar Association, the Governing Board of the American Medical Association, the American Public Health Association, the National Education Association, the National Council of Churches, and many other respected organizations;

2. The White Paper on Drug Abuse, dated September, 1975, from the White House Domestic Council, recognized that marijuana had a low potential for abuse and recommended "de-emphasizing" marijuana enforcement;

3. Each year more than 400,000 Americans are arrested on marijuana charges, resulting in the expenditure of an estimated $600 million in law enforcement resources. More than 90% of these arrests involve possession of small amounts. Marijuana arrests now comprise 69% of all drug arrests in the country;

4. National surveys taken by the National Institute on Drug Abuse indicate that 86% of the American adults now oppose the imposition of any jail penalty for minor marijuana offenses, and 52% favor only a fine and/or probation;

5. In Oregon, where a modified form of marijuana decriminalization was adopted in October, 1973, Drug Abuse Council surveys have shown absolutely no increase in marijuana smoking following the adoption of decriminalization;

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6. Dr. Robert L. DuPont, Director of the National Institute on Drug Abuse, the agency in charge of all government research into potential health concerns, stated earlier this year, upon the release of the Fifth Annual Report to Congress entitled "Marihuana and Health," ". . . at our current use levels and our state of knowledge, . . . there is no question that alcohol and tobacco are causing us far more health problems than marihuana does." Dr. DuPont also endorsed the concept of decriminalizing minor marijuana offenses.

It seems highly unlikely that President Ford will attempt to exploit the marijuana issue, despite his statement that he opposes marijuana decriminalization, since Betty Ford has publicly endorsed decriminalization and Jack Ford has admitted that he has in the past been a marijuana smoker. In fact, Mrs. Ford has said that if she were young today, she would probably try marijuana herself, equating it roughly with tobacco and wine. Thus, any attack from the Republicans on this point would likely emanate from Senator Dole, rather than President Ford.

Finally, I wish to complain about some damaging comments Governor Carter recently made following his wife's statement that all three sons had confided to her that they had smoked marijuana before they were married. The following day Governor Carter was asked about the situation and reportedly said:

1) that his concern about marijuana was partly based on the fact that marijuana is often used in conjunction with heroin and other addictive drugs; and,

2) that he is far more concerned about marijuana than he is about booze.

I assume that I do not have to point out that both of these statements are spectacularly unenlightened. The vast majority of marijuana smokers do not use heroin or other addictive drugs, and to even suggest that possibility is to perpetuate the myth that marijuana somehow "leads to heroin." As to the comparison with booze, Gov. Carter may be more comfortable with liquor, since his generation grew up with it, but the research on this point is rather conclusive. Alcohol is a particularly dangerous and addictive drug, which causes direct damage to several organs of the body. Marijuana is non-addictive, and has not been shown to cause any direct damage physiologically or psychologically, even in cultures such as Jamaica, Costa Rica and Greece where marijuana is used in extremely large doses, often over several years.

Should Gov. Carter feel that it is necessary to soften the potential adverse political impact of his marijuana decriminalization endorsement, he should stress that he continues to oppose the use of marijuana but believes a discouragement policy can be successfully maintained without treating the smoker as a criminal. He should not perpetuate the misinformation which has resulted in our current bankrupt drug policy in this country by exaggerating marijuana's potential for harm or by casually lumping it with the truly dangerous drugs such as heroin.

RKS:pes
cc: Mr. Joe Duffy
Stuart Eizenstat
Bob Havely
Chip Carter
Patrick Anderson

AUG 2 0 1976

UNIVERSITY of PENNSYLVANIA

PHILADELPHIA 19104

Please Reply to:
Philadelphia General Hospital
700 Civic Center Blvd.
Philadelphia, Pa. 19104

August 19,1976

Dear Adelaide,

Thank you so much for a very exciting morning and for listening so attentively and sympathetically.

When I returned to my office after the trip to Washington, I found the enclosed materials from Bob Jones. I'll get in touch with him in the morning and ask him to develop them further and send them on to you. — NO !

Also, I'll ask around the University about suggestions for coping with the limitations posed by the new campaign expenditures law. That is really a very disturbing bit of news. It may be that some of the management people will have an idea of how to optimize resources

With best wishes also to Mary and Judy,

Sincerely,

Mickey

Albert Stunkard M.D.

AUG 2 0 1976

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The Nation's First Hospital - Founded 1751

111 N. FORTY-NINTH STREET
Philadelphia, Pa. 19139
TELEPHONE 215-829-2282

August 13, 1976

Governor James Carter
Plains, Georgia

Dear Governor Carter:

The Benjamin Rush House Committee cordially invites you to be the featured speaker at the annual Benjamin Rush Picnic and Fair on September 11. The location would be the most appropriate spot in the country for you to deliver your message on health.

Benjamin Rush, M. D. is the "Father of American Medicine." He was the only Signer of the Declaration of Independence with a medical degree, the greatest medical teacher in our history, and the first internationally-known American physician. His campaigns on behalf of black Americans, the poor, the criminal, and the mentally ill make him a model for Americans today.

Benjamin Rush State Park is a new 275-acre park in the populous Northeast section of Philadelphia. It was created by the Commonwealth of Pennsylvania as a Bicentennial project, signed into law by Governor Milton J. Shapp last December. The house in which Benjamin Rush was born on Christmas Eve, 1745, will be re-erected in the Park.

Will you do us the honor of dedicating the new Park on September 11?

Our Picnic attracts 5,000 people, but will probably attract many more with your presence. It lasts all day. It is sponsored by many civic organizations, schools, and churches in the area. A high school band will play. You may land by helicopter, or you may come by motorcade up Roosevelt Boulevard, a prominent avenue lined by homes and stores. The mobile stage, complete with microphones, will seat about thirty

people. Last year all of the local politicians spoke, including Congressman Joshua Eilberg and State Senator Craig Lewis. The park adjoins Philadelphia State Hospital.

The enclosed brochure lists the many distinguished Americans who serve on our Committee, representing all of the organizations with which Rush was affiliated.

We invite you to speak at the site of the birthplace of the "Father of American Medicine."

Yours sincerely,

Robert E. Jones, M.D.

Robert E. Jones, M. D.
Chairman
Benjamin Rush House Committee

REJ:bp
Enclosure

HOW TO BE YOUR OWN BEST DOCTOR
(Working title; to be changed if possible)

Victor W. Sidel, M.D. and Ruth Sidel, M.S.W.

Prepared at the request of Parent's Magazine

July, 1976

You can guard your own health and the health of your family better than anyone else! You, as a non-health-professional know more about your own health and the health of your family than does your family doctor or your pediatrician, your school nurse or your pharmacist. Not only do you know when you feel fine and when you don't, but you also know, when you don't feel well, whether there is something going on in your life that may be a contributing factor, whether your "dis-ease" is due to tension or edginess or other factors. Similarly you know when your children are well, and can usually tell when that earache or sore throat or scrape is mild and transient--and simply needs reassurance and love--or when it requires more specialized diagnosis and treatment. We must realize that we are all--each of us--the best guardians of our own health and that of our families. If we believe that we can have the confidence--for confidence is the key--to protect our own well-being.

There used to be a time when there were many family doctors who knew their patients well and could themselves tell immediately when Mary had a minor intestinal upset which would disappear promptly or when her incessant crying meant that something far more serious was going on. The family doctor at his best knew that Mrs. Smith always had headaches; he reassured her and helped her to cope with them and to continue doing the things that she needed to do. And he knew that Mrs. Jones never complained about anything, so the pains in her head required a very different response. The doctor was a teacher and

adviser and often a friend. Unfortunately there was usually not much that doctors could do when their patients became seriously ill except worry with them and their families and try to prevent any unnecessary suffering. Of course, some exceptions existed. On the positive side, surgeons could at times prevent further disability or even save a life by a timely amputation or by the removal of a stone or a tumor. Physicians had some drugs, like digitalis for heart disease or quinine for malaria, which could relieve specific symptoms. On the negative side, some physicians resorted to a crude technology -- such as bleeding and purging -- and may have killed their patients or at least delayed recovery. But for the most part physicians were content to give advice, to use medicines to ease pain and suffering, and to permit nature -- which heals most illnesses if permitted to take its course unimpeded -- to do its work. Many physicians knew their patients well, visited their homes, knew their culture, and understood when intervention would be helpful or harmful.

But with increasing industrialization in the cities and mechanization on the farm, families moved to the cities, mobility increased, old neighborhoods were broken up, and the old relationship between a family and a family doctor who is teacher, adviser, and friend has become rarer and rarer. In fact, the family doctor (or general practitioner or primary care doctor) has become rarer and rarer as more and more doctors became specialists rather than general practitioners, began to be more concerned with the disease or with the diseased organ

than with the whole patient or with the family or with the social, economic, and emotional problems with which the family has to deal and which are the root of many of their illnesses.

The reasons for the changes in doctors included not only the industrialization and urbanization of life in general but especially the explosion of technology in medicine itself. Oliver Wendell Holmes told the Massachusetts Medical Society in 1860: "I firmly believe that if the entire materia medica as now used could be sunk to the bottom of the sea, it would be all the better for mankind -- and all the worse for the fishes." But by the 1920's hormones -- the first were insulin and thyroid hormone -- began to be available for use as replacements for patients who lacked enough of their own. In the 1930's sulfa drugs and in the 1940's penicillin and other antibiotics began to permit physicians to deal with infections that the body was unable to deal with. In the 1950's cortisone, ~~permitted the doctor to use~~ The introduction of another hormones but used in quantities far greater than the body normally used, ~~them to deal with~~ permitted treatment of specific problems such as arthritis or asthma. And in the 1950's and 1960's potent new tranquilizers--including, of course, thalidomide--were introduced. These increasingly powerful drugs--and increasingly powerful surgical techniques, such as open-heart surgery and transplantation of organs--helped many people to overcome their illnesses and to prolong their lives. But they also had other effects. The specific negative effects--such as adverse drug reactions and unnecessary surgery--we will return to in a moment. But the general negative effects were in someways even worse. The

doctor became more and more a technologist, requiring expert knowledge and a wide variety of laboratory techniques to aid diagnosis and treatment; there was little time or inclination to do the other things a doctor traditionally did for a family. Costs rose explosively because of the cost of the new equipment and of the army of skilled technicians needed to run the equipment and because the doctor demanded a new level of pay to compensate him for his longer, more specialized training and for the new pressures--such as the risk of malpractice--which the new technology and the new style of practice brought. Perhaps most perniciously, the doctor began to be viewed as the person who had a pill or procedure or a machine that could "fix" anything--and people began, as Ivan Illich has recently pointed out, to lose confidence in their own ability to cope with anxiety, illness, and death. The doctor often became Doctor Feelgood, Doctor Miracle Worker, and Doctor Expensive--and too rarely Doctor Education and Doctor Compassion and Doctor Coordination.

But these last services are still needed by families, and families must learn both how to provide some of them themselves and how to use doctors effectively to provide the others that their special training enables them to give. Furthermore, because of improvements in sanitation and in living standards, the leading causes of sickness and death are no longer the infectious diseases but rather chronic illnesses such as heart disease in which living habits and self-care play a most important role.

In short, we must look after our own health. We must know how to keep healthy; we must know when we are sick. We must evaluate when we do not need a professional medical worker and when we do. And above all, we must know how to work together with a medical professional once we seek his/her advice. For the old view of the doctor-patient relationship with the doctor as the authority and the patient passively taking advice must change; it no longer works. We must see ourselves as equal partners with medical professionals in protecting our health. For our health and the health of our children is, after all, our responsibility!

There are several levels of keeping ourselves healthy. The first, called "primary prevention," is to keep from getting a disease in the first place; accident prevention and immunization against infectious disease are examples. The second, called "secondary prevention," is to recognize certain diseases early and deal with them effectively so that they can be arrested and their complications minimized; examples are early detection and treatment of hypertension or breast cancer. The third level, called "tertiary prevention," involves rehabilitation, getting back to a full and productive life after an illness or while coping with a chronic illness or disability; examples include returning to optimal functioning after a heart attack or a stroke.

We can be the guardians of our own health first by heeding the advice given by wise physicians long before there were wonder drugs and heart transplants: eat in moderation; try to

live a balanced life with elements of work, relaxation and exercise; try not to get too frantic with the pace of life and, perhaps most important, find something outside yourself and your family to work and live for.

Along with the things we can do to promote health, we can actively attempt to avoid illness. Stop smoking for your own sake and, by example, to help your children not to begin. Avoid alcohol or use it in moderation, for the same reasons. Avoid foods with additives when fresh and unadulterated foods are available inexpensively (avoiding simultaneously the high prices and the fads of "health foods") for we really do not know the cumulative effect over the years of additives and can only suspect the worst.

Be concerned with hazards on the job, in the car, and in the home. About 14,000 American workers are killed each year in work accidents and over 2 million are either permanently or temporarily disabled as a result of work accidents and occupational disease. Some 50,000 deaths and 2 million injuries are caused by automobile accidents each year. Automobile accidents are the leading cause of death among Americans aged 5 to 35. It has been estimated that 14,000 lives--25% of the annual motor vehicle fatalities, could be saved if everyone simply wore their seat belts.

We must make our houses safe for small children -- placing detergents and other poisons higher than the child can reach or climb or locking them up and knowing where to call and what to do when he does find the forbidden bottle and

drinks some of the contents. Covering electric sockets, protecting stairs, closing and locking windows, placing bars over open windows high above the ground are additional things we can do.

Another way of preventing illness involves taking actions which are thought of as "medical" responsibilities but need to be directed, and sometimes done, by ourselves. We must make sure our children are immunized appropriately. As we all move from one neighborhood to another, from one doctor or clinic to another, no one but us will make sure that our children have been immunized against polio, diphtheria, whooping cough and tetanus. Measles vaccine has been available since 1963 and there is no need for another American child to ever again have measles; yet over one-third of American children, 1 to 4 years old have not been immunized against measles despite the fact that deaths from measles occur primarily in children less than 5 years old. Is your child or the child of one of your neighbors among the unprotected ones?

-- Secondary prevention --

Early detection of curable or reversible illness is our responsibility too. Children's development -- physical and emotional -- must be carefully watched and preferably charted, either by ourselves or by the appropriate health professional, not necessarily a doctor. For adults it means examination for problems such as high blood pressure or breast cancer. Again this needn't be done by a doctor. The best breast exams are done by women on their own breasts -- if they have been taught how to do it and if they are motivated to do it regularly and

thoroughly. It also means recognizing and dealing with danger signals even when they don't yet interfere with our work or make us feel "sick;" the American Cancer Society lists the danger signals of cancer, for example, as: a change in bowel or bladder habits, a sore that does not heal, unusual bleeding or discharge, thickening or lump in the breast or elsewhere, indigestion or difficulty in swallowing, obvious change in a wart or a mole or a nagging cough or hoarsness.

Guarding our own health also means knowing and admitting to ourselves when we don't feel well and seeking advice from a medical professional. And once we consult a professional, we must know our rights within that relationship. A doctor or a dentist or nurse is not the final authority. They by no means know all the answers and we must feel comfortable asking all the questions we can think of to better understand and manage our own health status.

What is my diagnosis and how did you arrive at it? Each diagnostic test ordered should generate its own questions. For example, if X-rays are ordered one might ask: Why are you recommending that X-ray? Is it essential for my diagnosis? Is it worth the radiation hazard, however small? Is there anything I have to do (like fasting for certain intestinal X-rays) to prepare for it?

What is your recommended treatment, how did you decide on it, and what are the alternatives? Questions about treatment might include, if medications are ordered: What is the name of this medication? What is it suppose to do for my

condition? What are its possible side effects and its cost? Is there an alternative, including not using a drug at all, which might have fewer side effects or might be less expensive? How should the drug be taken and what precautions, if any, should be observed while taking it? When should I report back to you? Or a more specific example, why does my child need to take antibiotics for ten days for his strep throat when his throat will probably feel better in twenty-four hours?

These questions about drugs may sound complex, even presumptuous, and the doctor may complain that he or she doesn't have the time to deal with them. But we live in an age of powerful medical techniques and drugs which often cause more damage than cure. Who can forget the thalidomide tragedy in Europe during the 1950's when children were born so severely deformed because of ignorance of the damage a drug can do? American doctors write twice as many prescriptions per patient as do Scottish physicians, and the rate of side effects is about twice as high here as in Scotland. Approximately 300,000 people are hospitalized annually in the United States because of drug reactions, making this one of the 10 leading causes of hospitalization, and approximately 30,000 people die each year as a result of these reactions.

We shouldn't take any medication without first understanding the reason for the prescription, exploring the alternatives and the possible side-effects. Conversely, once these questions are answered to our satisfaction we have a responsibility to take them as we have agreed upon with our

doctor. A study of out-patients at the University of Rochester School of Medicine, for example, found that 51% of patients never took the drugs that were prescribed for them; this seems most often true when the drug is prescribed for a chronic condition which produced little or no symptoms, like high blood pressure, and the drug may make the patient feel worse than does the disease. But over the long run the consequences of not taking the drug will be worse. And, of course, it goes without saying that one should never take drugs that were prescribed for some previous illness or for someone else without a full understanding of what one is doing or a consultation with your physician.

If our physician recommends surgery, we have the right -- indeed the responsibility -- to understand fully the reasons for the surgery, the implications, the possible complications, and again the alternatives. And then we should feel perfectly free to get a second opinion because physicians are far from infallible and because -- for a variety of reasons -- some apparently are not very ethical. A great deal of surgery is performed in the United States that would seem to be unnecessary.

The United States, for example, has about four times as many people as does Great Britain, but close to 8 times as many surgical operations. Within the United States, among Federal employees covered by two different types of health insurance plans, those covered by Blue Cross (where doctors receive a fee for each service) had about 50% more surgery performed as did those who were enrolled in a prepaid group

health plan (where the physicians are paid the same amount whether they operate or not). And in programs in which a second opinion is required before surgery is performed, about 18% of the operations recommended by the first surgeon were felt to be indefinitely postponable or unnecessary by the second surgeon. If one projects this figure to the 14 million elective operations performed in the United States each year, some 2½ million operations and some 12,000 deaths associated with those operations may be unnecessary. Again, this is not meant to discourage necessary surgery, which may be life-saving, but to encourage entering into the surgery as knowledgeably as possible.

Not only should we as adults insist that we understand every step of a medical procedure but we must also insist that our children understand what is happening when they go to a medical professional. They, too, have the right, for example, to know exactly how the dental hygienist will clean their teeth, how the hygienist or the dentist will examine their teeth and the process of having a cavity filled. Or if a child is to have an immunization, he should be told why, how and how much it will hurt. And unfortunately sometimes it is up to us as parents to protect our children by insisting that they have a right to this knowledge. Medical workers are often busy and harassed; how much easier it is to just give that shot and let the mother cope with the tears. But it is, of course, not the way to develop a knowledgeable, trusting, cooperative patient or, even more important, a knowledgeable,

trusting, cooperative person.

What of our role as individuals with, or as parents of childrens with, a chronic illness -- high blood pressure, diabetes, epilepsy? The most important element in managing and minimizing the effects of chronic illness is thoroughly understanding the illness itself, and ways of managing the illness medically for it is clear that the individuals who thoroughly understand their condition can deal with it with minimum disruption to their lives. Again we cannot rely on medical professionals to be our authorities; they can provide facts and advice, but we are the authorities on our own health status and care.

It is clear now that an informed patient who is confident of his ability to deal with his own illness fares far better than one who passively sits back and takes little responsibility. The recent emergence of self-help groups not only in the areas of weight reduction and alcoholism but also in the areas of chronic illness indicates a greater awareness and readiness on the part of patients to manage their own health status. It is also clear that individuals who have experienced similar problems can often help one another far better than a professional can. We must become informed about our own health problems, help ourselves and then perhaps reach out and help others.

Thus far we have focussed primarily on our individual health problems and their prevention and care. But there are many aspects to protecting our health that cannot be accomplished on an individual basis. We cannot wipe out the rats in our

urban tenements individually. We cannot as individuals eliminate the lead-based paint from apartment walls which when eaten by small children causes severe illness in thousands each year. We cannot minimize air and water pollution individually. We cannot minimize traffic accidents through increased traffic lights and crossing guards as individuals. We cannot as individuals discipline incompetent and greedy physicians and surgeons. We cannot as individuals bring about a national health program which will assure all people accessible and responsive health care with minimal charge at the time of need. For these and many other crucial protections to our health and well-being we must band together and work collectively within our own neighborhoods, within our own communities. For unless we work together to assure ourselves and our families of a safer and healthier environment, we will individually suffer the consequence.

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DRAFT SPEECH

PREVENTION: THE NEXT BIG STEP TOWARD HEALTH FOR AMERICANS

When asked about health problems Americans still put the high cost of health care at the top of the list. We do so because we now spend over eight percent of our Gross National Product for health care, about twice the proportion we spent in 1950. The typical American works one month each year - more than he gets for vacation - just to support health care.

We must and we will find ways to reduce the cost of health care, first by reducing waste. For example, we have one-third too many hospital beds in some parts of the country. Furthermore, a recent study by surgical associations showed that we have plenty of general surgeons and are now training more than we need. On the other hand we still need more primary care doctors.

Also, we must and we will find ways to handle the proper cost of health care more equitably - through national health insurance.

Yet as Americans we realize that something more is necessary for health. The most advanced medical technology, whatever it costs and however we pay for it, does not assure health. (In fact we now spend far more for dying than we do for maintaining health.)

What is missing?

Prevention is the main thing we need to maintain health. Yet in the early 1970's our nation devoted to prevention in health care only

about two percent of what we spent totally for health care. Health insurance plans by and large refuse to pay for preventive services. The Federal government in the Nixon-Ford period cut back on immunization programs for children, failed to support Pap tests that would reduce cancer deaths among women, and generally neglected prevention in national health policy.

What was the result?

The result was that:

- outbreaks of measles occurred. In 1975 San Franciso had several hundred cases, exceeding the number in any year for the preceding seven years. That is a sad commentary on the fact that effective measles vaccine has been available since 1963.

- thousands of women continued to die of cervix cancer, with almost completely preventable deaths. In 1974 one-fourth of the women in America, mostly poor women who have a large amount of the disease, had not been tested even once with the Pap smear. Since that excellent cancer-prevention technic was made available in 1943, more than a quarter-million American women have died unnecessarily from cervix cancer - and thousands are still dying.

- only about one-fourth of American men with high blood pressure in 1974 were under adequate control with drugs that can prevent death from that condition.

The list could go on and on.

Besides considering all these specific preventable diseases and deaths one can take stock of our health situation in another way. We can consider total deaths, at different periods of life. We have made considerable progress against infant mortality and other deaths among children and young people. Beginning at age 45, however, the situation

is not good. For example, the life expectancy of American men at age 45 increased from 1900 to 1970 only about four years - in spite of all the technical advances in anti-biotics, in surgery, and in many other aspects of medicine.

The main explanation for this poor health record beyond the age of 45 lies in several personal habits we have developed in recent decades. Smoking cigarettes, excess consumption of alcohol, eating too much of the wrong kinds of food and exercising too little - these habits are part of a lifestyle which results in much heart disease, lung cancer, hardening of the liver, and many automobile accidents. It is such conditions that constitute leading causes of death today. Preventing these killers is largely a matter of individual habits. Each person decides in effect each day whether he will smoke cigarettes, drink alcoholic beverages and how much, eat reasonably and be physically active.

These day-by-day decisions, beginning early in life, determine in large part how long and with what degree of health an individual will live. For example, a man at age 45 with poor health habits has a total life expectancy of 67 years; a man at the same age with good health habits has a life expectancy of 78 years. Compare that difference of 11 years which depends on following a few, simple rules of good health (that also make you feel better day-by-day) with the four years of life extension achieved in our nation from 1900 to 1970.

I have tried to be very specific about what can be accomplished through prevention because we are not dealing with some vague generalities. We say "an ounce of prevention is worth a pound of cure" but we do not practice it systematically yet, either in our health care system or in our individual habits.

Only now are we beginning to realize the extent to which we could improve our health by focussing more on prevention. That will mean turning the health programs of the Federal Government more toward prevention. It will mean turning health insurance plans, the ones we have now and the national plan we intend to develop, toward prevention. It will mean turning the life-style, the day-by-day habits, of the American people toward health maintenance. The manner of life we must cultivate for health is a joyful and abundant one, making every day better living and adding years at the same time.

Nothing is more important for an American president than to lead the nation toward peace in the world and health and well-being at home. I intend to do both, with all my energy.

In the health field I want to see that every child and every mother receives the maximum protection now possible through the advances of medical science, every school child the health care that will favor the best education, every adolescent the health examination and counselling that will permit entry to adult life with maximum health and outlook for maintaining it, every worker the protection needed against chemical poisons and other hazards on the job, every person in this country throughout adult life from age 18 to 100 the special procedures appropriate to each age that will help ward off disease and promote health. I want to see the health care system of this country turn toward the people, join with them in a partnership for health - each doing what is best for health, for self and others. That is the meaning of prevention.

Dedicated to that noble purpose we can take not a small step but a big stride toward improving health for all.

For too long we have neglected prevention. Our health care dollars have been focussed too much on expensive technology, helpful perhaps to

a few but not doing what should be done for the people as a whole. Instead of working with all the people to advance health through prevention we have been spending too much on too few with too little benefit.

We must re-direct the tremendous resources that our nation has committed to health care - the thousands of fine institutions, the millions of well-prepared health workers, the billions of dollars we spend each year in the name of health - in a mighty partnership with the people themselves to advance health mainly through prevention.

I pledge that in its management of present health programs; in the development of national health insurance; in telling people "like it is" about health - that each person carries responsibility as well as do doctors, hospitals and government - my administration will lead the American peopleaway from the frustrations and failures in the health field to the great achievements that are now possible.

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make our input into this exciting opportunity voluntarily and immediately or whether we will choose to wait and dissipate not only our advantage but also our eventual self-determination in this matter. In my view, truly involving the community in medical education has the potential of being the single most important medical educational achievement of this century.

Toward a Growth Model for Medicine

Harold B. Wise, M.D.

My response to the Institute on Primary Care was an emotional one. There is something about the artificiality of the convention hall and the hyperrational presentation of problems that for me fails to convey the magnitude of the crisis existing in primary care today, a crisis that I believe encompasses the interactions of all health workers and the patients for whom they are responsible. In my view, part of the problem is that physicians are not adequately prepared to relate effectively to patients at the interpersonal level in all settings—private practice, ambulatory care, and the hospital. The public dissatisfaction is enormous. What I feel is called for is a major restructuring of our educational system to develop practitioners who are sensitive to the needs of individuals and their families.

My comments here are by way of response to three issues raised by Dr. Henry M. Seidel (Chapter 3) and developed by Dr. Robert L. Evans (Chapter 6). The first concerns the content of the new curriculum in primary care. The second involves the sites for training and the different kinds of faculty and students we need in the new setting. The third concerns the political issues of the reordering of priorities.

Dr. Wise is director, Residency Program in Social Medicine, and codirector, Institute for Health Team Development, Montefiore Hospital and Medical Center, New York.

New Training Models

What are we as physicians fundamentally about—the treating of disease only or, in addition, helping people to live and grow? Abraham Maslow said if your only tool is a hammer, you tend to see every problem as a nail (1). Unfortunately, medical students and house staff spend most of their time learning how to deal with serious illness. Like "Sesame Street," which conditions children to be stimulated every few seconds, the hospital conditions medical students and house staff to the maximal stimulation of intensive care medicine.

If a person's heart stops, students learn there is a technology to deal with this: an army of white-coated residents descends on the patient and, through horn-rimmed glasses, stare at the electrocardiogram tracings making serpentine movements through the I.V. fluid spilled onto the floor. Here the disease model is useful and the metaphor of the magic bullet (that is, the resuscitation

team as the "injection") provides a framework for an energetic response.

But the disease model is of limited use, as evidenced by a decreasing interest in the patient on the part of the house staff as the heartbeat returns to normal. After the third week, only the intern shows up at morning rounds to see the patient. At this point, instead of dealing with a cardiac arrest, house staff faces a person with a damaged heart who must learn to live with incredible life changes. And for this situation members of the house staff have very few answers. Many members of the house staff see their role as limited to writing discharge orders with enough digitalis, diuretics, and sedatives. The problems the family faces—a husband and father suddenly dependent, a wife who may have to become the major income-producer, and children who may face the prospect of moving into their late adolescence without a functioning father —are left to the family physician (if any). Or they are left to the physician working in the outpatient clinic who also may lack training in family dynamics and human intervention skills. At this point, the disease model proves inadequate for the primary care practitioners.

To say it another way, while ankle swelling or basal rales may respond to an injection, in a vast number of situations what is required is managing the care of the patient and his family. Furthermore, understanding a management model would help the primary practitioner more effectively to coordinate subspecialty care and social resources when necessary. Training in the management model of care, with opportunities for following patients over several years, is rarely found in the curriculum of medical students or house staff.

Up to this point, I have dealt with alternative models and strategies used to deal with disease and its management. As long as disease is the focus, the hospital will continue to be the major site for learning and intellectual stimulation. Primary care practitioners may try to match the excitement of crisis medicine by developing a problem-oriented practice, using epidemiological techniques to monitor their practice, or introducing preventive techniques, but there is nothing in primary care that allows the physician who focuses on disease to express himself as fully or as dramatically as he could in the hospital. Young primary care practitioners switch into high gear when confronted with a "hospital-type" case.

The focus of medicine, as illustrated by the hospital, is on disease. The assumption is that if you remove disease, then good health will occur. House staffs are trained to see every problem as an illness and the patient as sick until he is proven well.

There is another approach which exists in some of the newer psychologies which may be useful to the primary care practitioner. This approach requires the practitioner to deal not just with disease but to assist patients and families in their normal development. We need a developmental model for individuals and families at all phases of life where primary care practitioners can creatively assist in helping people grow. I am interested, for example, in knowing the timing and the kind of intervention that might be helpful in converting certain classical life crises into growth experiences. One would be the birth of the first child, with its concomitant radical effects on mobility and life style. Another concerns the family with children reaching adolescence –a middle-aged father in a stressful job, his adolescent children

coping with peer-group pressure, the mother aware that she must prepare to be occupied in new areas as her children get ready to leave home. If things go wrong, the medical profession is confronted with a son on drugs; a daughter looking for an abortion; a wife developing a breast lump; a husband trying to accommodate to a career-changing crisis, his first affair, and the onset of angina; a grandparent discovering a terminal illness.

Such crises are often predictable. It is my belief that if they are predicted the resulting energy may be turned into positive channels for growth rather than illness. What is necessary are strategies to help the adolescent children individuate and leave home without self-destruction, the parents to move into new life roles as the children depart, the grandparents to prepare themselves and their families for their final experience in the body—dying. None of these conditions is traditionally or exclusively medical, but their combined effects call for the development of strategies and techniques designed to help practitioners of primary care to intervene effectively in the family system in a way to promote its healthful growth.

These models exist in some of the psychological therapies. They are now being developed in the field of medicine. What is needed more is research and demonstration of these medical growth models.

Students, Faculty, Environments

Most medical students have been groomed from early childhood to carry out the doctor role. And no group goes through such a compressed experience, postponing what most people call living. What results are students who are goal-oriented and highly successful achievers but whose spontaneous feelings have often been repressed and whose intuitive faculties have never been encouraged. The approach is better geared to the production of applied biologists than practitioners supposedly skilled in human interaction.

The training of many existing faculty members was covertly designed to desensitize them. My classmates and I had cadavers as first patients—with no preparation for the emotional impact of dealing with dead bodies. We learned to objectify patients, marking out their lungs with wax crayons; 10 of us queued up to listen to a heart murmur or feel a rectal tumor. The message was to become distant. Feelings and empathy were ignored, and the grand old practitioners demonstrated bedside manner by warming up the head of the stethescope, ignoring the fact that the patient lay unclothed in an amphitheater pit—a "case" to 150 medical students.

The internships are the finishing blow. The person least prepared to deal with critical problems is at once confronted with making major decisions alone—inflicting pain (the first lingua pulpal, sigmoidoscopy, bone marrow); dealing with patient dependency, anger, transference, his own sexual feelings; getting the autopsy consent to boost the hospital's autopsy rate. By the end of the eighth week of 12-hour days, adjusting to a new city and perhaps to a recent marriage, the deeper feelings exploding, many house staff members go into a mild anxiety state. There is a brutalization of both medical students and house staff by the system. You cannot ask students to be any nicer to patients than faculty members are to students. Unfortunately, the resident is in the library reading journals, and the faculty is playing attending games. Inadequate faculty re-

sources to help deal with these feelings and unfair distribution of work make for an extraordinarily difficult time for interns. Most house staff members soon learn that they must turn off their feelings, ignore their standards of humaneness, and limit themselves to the technological aspects of care. They put on weight, their glasses become thicker, and they spend more time looking at X rays and laboratory results or attending conferences than they do in patient contact. They disappear during visiting hours.

Furthermore, the selection process into most medical schools and house staff programs favors high achievers, goal-oriented people. The process does not select people who are warm, empathic, genuine, or skilled in human interaction. Often the applicant's commitment to medicine is more a matter of fulfilling his or her family's expectations than any deep personal commitment to the field. In my view, the human qualities of the students and faculty are more important than their ability to learn the technical aspects of care. In any event, focusing in on the "healing" qualities of students and faculty ought to be part of the overt criteria of a changed selection process.

It takes several years to develop the empathic and interpersonal skills of a practitioner, to be able effectively to assist students or house staff members to develop their feelings and intuitive faculties, and to experience psychodynamic family and growth models of interaction and development, all of which are critical aspects of the healing encounter.

A word of caution here. If one opens up these aspects of a person, there must be a staff that is loving and an environment that is supportive. Most hospital environments as they currently exist—where practitioners encounter daily the deepest of pain and too often a lack of emotional support from their coworkers—do not represent such an environment. Recognizing the contrary arguments of costs, the training environment for the future primary care practitioners must be in warm and protective ambulatory and hospital settings.

Reordered Priorities

Five years ago, as poverty disappeared as a national concern and primary care programs began to emerge as the answer to consumer complaints, the traditional departments used two kinds of cop-outs to avoid getting involved. The first was to use the technique of the armchair radical—to declare the problem was so great that a fundamental restructuring of society was necessary; this, of course, allowed people to function in the same old way.

The second cop-out was to develop departments of community medicine, ambulatory care, family practice, and paramedicine—you name it. Newly created or renamed, they functioned as the garbage can of the medical institution, assuming the responsibilities traditional departments wished to ignore. Search committees consulted with public relations departments to formulate the right come-on in the letter of recruitment: "... hundreds of thousands of inner-city dwellers, desperate for medical care services, anxious to participate in policy formulation...." The job carried with it a high salary, a few budget lines, and the possibility of "bending the usual criteria for an academic appointment in the medical school." A sacrificial lamb was recruited, who soon found the need for another medical school, school of nursing, and school of social work to deal with the new job.

This person became the buffer between the institution and the "community" and was at home in neither camp. When problems occurred, the search committee was nowhere to be found.

For the few new departments that did survive, what we see now are political struggles for staff, for faculty, for curriculum time—often with enormous energy going into the political struggle. In my opinion, the problems of developing an adequate educational strategy for primary care will not be met by a tinkering with the status quo. A major change in the focus and deployment of resources will be necessary in most institutions if primary care education is to succeed.

To end on a positive note, there is one approach that I have seen work. The chairman of a department of medicine decides to delegate responsibility for the department's in-hospital capability to an assistant. This frees the chairman to move, with an enthusiastic group of house staff and attendings, to the primary care area. His presence as a role model and his obvious commitment to primary care carry enormous weight and greatly enhance the influence of primary care in the institution. House staff and attendings, under this umbrella, provide the energy for curriculum development and primary care strategy.

Many chairmen, of course, cannot make such a mid-life career change, nor is it appropriate for even the majority of them to leave an area where they have accomplished so much. For the adventurous minority, however, who see the need for a fundamental reordering of priorities as well as the critical importance of the human dimension in primary care, the challenge is great. No other group has as much leverage or as much going for it to help it to succeed in making the changes so desperately needed if the kind of medical care the public is demanding is to become a reality.

Reference

1. MASLOW, A. *Psychology of Science: A Reconnaissance*. Chicago: Henry Regnery Co., 1969.

University of Pittsburgh

GRADUATE SCHOOL OF PUBLIC HEALTH
Department of Health Services Administration

b: MEK
WHITE

Reply 8/23/76 GE

August 10, 1976

Ms. Mary King
Mary King Associates
2000 P Street
Washington, DC 20036

Dear Mary:

Since Judy Lipschitz tells me that you are spending the week in Atlanta, I shall send a copy to both your Washington and Atlanta addresses.

Thank you for your kind comments on the discussion on preventive medicine which I sent to you. You asked for the source of my statement suggesting that the present proportion of Federal funds devoted to primary prevention could be increased 10 fold with an estimated 100 fold improvement in the health of the American people.

The source for this statement comes from "The Analysis and Evaluation of Public Expenditures: The PPB System (U.S. Congress, Joint Economics Committee, Subcommittee on Economy in Government, 1969). See attached xerox copy. From the graph, you can readily see that the committee suggests a savings in excess of $3 billion resulting from programs in driver education and safety which cost only a few million dollars. By contrast, there is a savings of $8.5 to 10 billion from cervical cancer screening which has a program cost of $300 to 400 million. In the first instance, the cost benefit ratio is roughly 1 to 1,000. In the second, it is roughly 1 to 25. My estimate of a 100 fold improvement was simply a rough estimate, one that seems to be justified.

Again, please accept my willingness to be of whatever assistance I can be with respect to the campaign.

Sincerely,

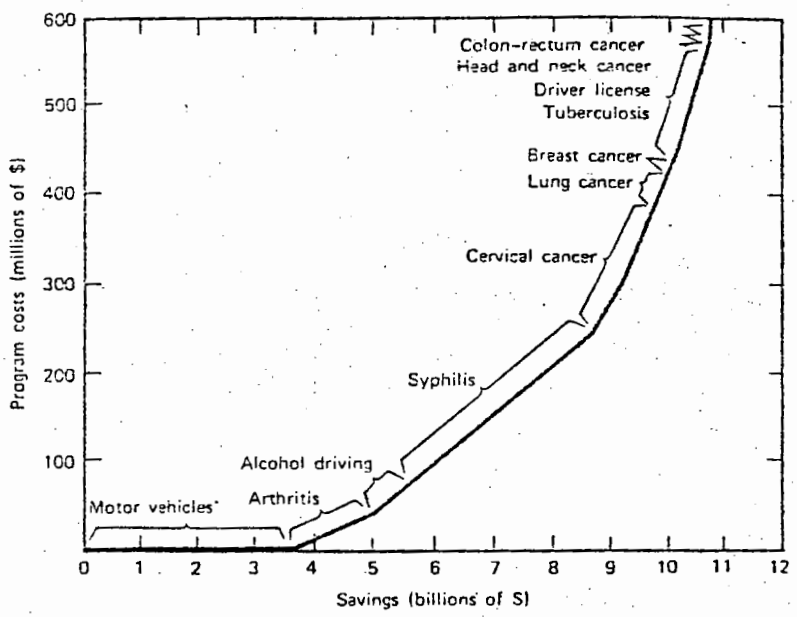
Gordon

Gordon K. MacLeod, M.D.
Professor and Chairman

GKM/sjc

Attachment

PITTSBURGH, PA. 15261


Program costs (millions of $)
600
500
400
300
200
100
0
1
2
3
4
5
6
7
8
9
10
11
12
Savings (billions of $)
Colon–rectum cancer
Head and neck cancer
Driver license
Tuberculosis
Breast cancer
Lung cancer
Cervical cancer
Syphilis
Alcohol driving
Arthritis
Motor vehicles

Summary of "Our Health and the Way We Live"

1.) Massive and growing medical expenditures — have produced a disappointing national health record.

2.) Greater expenditures will not help. Prevention will

3.) Particularly since much of our illness is caused by the way we live and can be lessened by changing the way we live.

4) Examples: automobile accidents - leading cause of death of the young
coronary heart disease - " " " " " " older

5.) Each is strongly determined by personal habits — examples
" has been helped by changing " "
" can be helped much more by greater changes in habits

6.) There are many other such problems: lung cancer, alcoholism, dental disease

7) The excuses against action:
A. We can't change habits — We can
B. Bad health habits are personal matters — Not at current costs
C. Big medicine will take care of it anyway - Big Medicine can't
D. Scientists aren't sure of all the fine points - Enough is known for action

8.) A three-point program:
A. Change incentives to promote health as well as care for illness
B. Expand health education
C. Enlist many voluntary groups in a massive effort to improve our health

control of these disorders in the future.

Prominent among these scientists are Dr. I
President of the Sloan-Kettering Cancer Cente
Berliner, Dean of the Yale Medical School and
Seldin, Chairman of the Department of Medicin
Southwestern Medical School in Dallas.

Strongly espousing the theme of this talk
Knowles, President of the Rockefeller Foundat
lesser extent, Dr. Theodore Cooper, Assistant
for Health.

3. Recommendations for decreasing smoking
to the strong opposition of the powerful toba
The power of this lobby, which even Lyndon Jo
challenge, is not to be underestimated.

The counter argument is that cessation of
single major health change which could yield
benefits. Nothing that could be done in the
delivery field could come close to the benefit
by stopping smoking.

It would appear that there are three strate
ed in the face of the oppositon of the tobacco

A. Decrease the emphasis on smoking cessat
do not mention it in this talk.

B. Increase the opposition to smoking by s
interventions as subsidies to farmers to chang
growing, as was done in Turkey with poppy farm
increase in taxes on cigarettes.

C. The most reasonable, approach is a mode

Political Considerations Regarding Talk on

"Our Health and the Way We Live"

1. The first question is whether the topic of lifestyles and personal habits should be considered at all by a presidential nominee. The argument will be made that this represents government intervention in the private lives of people and that even that it constitutes invasion of privacy.

The counter argument is that we are proposing to help people to help themselves, become more independent of government and medical establishments and thereby actually to increase their independence.

2. The second challenge will be on the scientific base of the proposed recommendations. There is a strong group of establishment scientists who will say:

A. The scientific base for believing that changes in lifestyles and personal habits will affect illness is still of uncertain strength. Although there is little argument about the benefits of stopping smoking, there is still disagreement about matters such as the ill effects of obesity and high fat diets.

B. These same establishment scientists believe that medicine has no business involving itself with the way that people live, and that it should confine itself solely to "medical", ie. pharmacological, treatments.

C. They also argue that equivalent money spent on basic biochemical research would give more promise of understanding of underlying mechanisms and of possible pharmacological

pressures encouraging people to stop smoking. Such a program seems in line with the actions of the Surgeon General and his 1965 report on smoking and with progress that has been made since that time in the area of public policy.

4. Incentives to individuals in decreased premiums for insurance and tax deductions for favorable changes in health behavior could be looked on as discriminating against individuals who were at higher risk of illness.

The counter argument here is that the opportunity for making favorable health changes is open to everyone and hence does not involve discrimination.

5. No mention has been made of drug abuse--certainly a problem of life style and personal habit.

This was done partly because it would seem a topic better suited to a mental health message and partly because it is so commonly associated with the ghetto that it might turn off a middle class audience to which the current talk should primarily appeal.

6. The "new treatments" for overetting, smoking etc. to which reference is made are behavior modification. The term was not used because of it current bad press, being associated with such dissimilar treatments as electric shock and psychosurgery. If pressed, it can be cited, or a currently fashionable alternative, "social learning theory".

7. Commercial organizations are mentioned by name in several instances: Weight Watchers, Diet Workship, Blue Cross, etc. It may be desirable to delete these references in order to avoid

advertising them. On the other hand, many people are associated with these organizations and specific references might appeal to them.

8. Favorable mention is likewise made of industries whose record has been poor in regard to health: advertising, food industry, communications industry.

Here I have taken my lead from Governor Carter, citing the good that they have done and urging them to do more. It seems to me a reasonable strategy.

The general philosophy of the talk and a fair amount of the facts ~~were obtained from~~ are outlined three key books:

(1)"A New Perspective on the Health of Canadians", Marc Lalonde, Minister of National Health and Welfare,Government of Canada,1974

(2)"Conference on Future Directions in Health Care" Sponsored by Blue Cross Association,Rockefeleer Foundation,Health Policy Progra University of California,San Francisco ,1975

(3)"Who Shall Live?" Victor Fuchs, Basic Books,1974

Major fact book is "Health:United States,1975,DHEW Publication No.(HRA)76-1232

Rcvd
8/16/76

UNIVERSITY OF CALIFORNIA, LOS ANGELES

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SANTA BARBARA • SANTA CRUZ

OFFICE OF THE DEAN

SCHOOL OF PUBLIC HEALTH
THE CENTER FOR HEALTH SCIENCES
LOS ANGELES, CALIFORNIA 90024

2 August 1976

Ms. Mary King
c/o Carter Presidential Campaign
2000 P Street, N.W., Room 511
Washington, D.C. 20036

Dear Ms. King:

In response to your request, I am submitting a draft speech on prevention. If you or others have suggestions about it, or would desire further work on it, please let me know.

Also attached is a copy of a letter recently addressed to Senator Javits concerning his bills to establish a system of national health insurance for mothers and children, to provide for comprehensive maternal and child health care practices. Some years ago I was deeply involved in the matter of developing a national health insurance program for mothers and children; possibly that influenced Senator Javits to include me on his list of persons to be consulted about his present bills.

Under separate cover, I am forwarding to you backup and related materials concerning the draft speech on prevention.

Sincerely yours,

Lester Breslow

Lester Breslow, M.D., M.P.H.
Dean

LB:bb
attachments

2 August 1976

DRAFT SPEECH

PREVENTION: THE NEXT BIG STEP TOWARD HEALTH FOR AMERICANS

When asked about health problems Americans still put the high cost of health care at the top of the list. We do so because we now spend over eight percent of our Gross National Product for health care, about twice the proportion we spent in 1950. The typical American works one month each year - more than he gets for vacation - just to support health care.

We must and we will find ways to reduce the cost of health care, first by reducing waste. For example, we have one-third too many hospital beds in some parts of the country. Furthermore, a recent study by surgical associations showed that we have plenty of general surgeons and are now training more than we need. On the other hand we still need more primary care doctors.

Also, we must and we will find ways to handle the proper cost of health care more equitably - through national health insurance.

Yet as Americans we realize that something more is necessary for health. The most advanced medical technology, whatever it costs and however we pay for it, does not assure health. (In fact we now spend far more for dying than we do for maintaining health.)

What is missing?

Prevention is the main thing we need to maintain health. Yet in the early 1970's our nation devoted to prevention in health care only

about two percent of what we spent totally for health care. Health insurance plans by and large refuse to pay for preventive services. The Federal government in the Nixon-Ford period cut back on immunization programs for children, failed to support Pap tests that would reduce cancer deaths among women, and generally neglected prevention in national health policy.

What was the result?

The result was that:

- outbreaks of measles occurred. In 1975 San Franciso had several hundred cases, exceeding the number in any year for the preceding seven years. That is a sad commentary on the fact that effective measles vaccine has been available since 1963.

- thousands of women continued to die of cervix cancer, with almost completely preventable deaths. In 1974 one-fourth of the women in America, mostly poor women who have a large amount of the disease, had not been tested even once with the Pap smear. Since that excellent cancer-prevention technic was made available in 1943, more than a quarter-million American women have died unnecessarily from cervix cancer - and thousands are still dying.

- only about one-fourth of American men with high blood pressure in 1974 were under adequate control with drugs that can prevent death from that condition.

The list could go on and on.

Besides considering all these specific preventable diseases and deaths one can take stock of our health situation in another way. We can consider total deaths, at different periods of life. We have made considerable progress against infant mortality and other deaths among children and young people. Beginning at age 45, however, the situation

is not good. For example, the life expectancy of American men at age 45 increased from 1900 to 1970 only about four years - in spite of all the technical advances in anti-biotics, in surgery, and in many other aspects of medicine.

The main explanation for this poor health record beyond the age of 45 lies in several personal habits we have developed in recent decades. Smoking cigarettes, excess consumption of alcohol, eating too much of the wrong kinds of food and exercising too little - these habits are part of a lifestyle which results in much heart disease, lung cancer, hardening of the liver, and many automobile accidents. It is such conditions that constitute leading causes of death today. Preventing these killers is largely a matter of individual habits. Each person decides in effect each day whether he will smoke cigarettes, drink alcoholic beverages and how much, eat reasonably and be physically active.

These day-by-day decisions, beginning early in life, determine in large part how long and with what degree of health an individual will live. For example, a man at age 45 with poor health habits has a total life expectancy of 67 years; a man at the same age with good health habits has a life expectancy of 78 years. Compare that difference of 11 years which depends on following a few, simple rules of good health (that also make you feel better day-by-day) with the four years of life extension achieved in our nation from 1900 to 1970.

I have tried to be very specific about what can be accomplished through prevention because we are not dealing with some vague generalities. We say "an ounce of prevention is worth a pound of cure" but we do not practice it systematically yet, either in our health care system or in our individual habits.

Only now are we beginning to realize the extent to which we could improve our health by focussing more on prevention. That will mean turning the health programs of the Federal Government more toward prevention. It will mean turning health insurance plans, the ones we have now and the national plan we intend to develop, toward prevention. It will mean turning the life-style, the day-by-day habits, of the American people toward health maintenance. The manner of life we must cultivate for health is a joyful and abundant one, making every day better living and adding years at the same time.

Nothing is more important for an American president than to lead the nation toward peace in the world and health and well-being at home. I intend to do both, with all my energy.

In the health field I want to see that every child and every mother receives the maximum protection now possible through the advances of medical science, every school child the health care that will favor the best education, every adolescent the health examination and counselling that will permit entry to adult life with maximum health and outlook for maintaining it, every worker the protection needed against chemical poisons and other hazards on the job, every person in this country throughout adult life from age 18 to 100 the special procedures appropriate to each age that will help ward off disease and promote health. I want to see the health care system of this country turn toward the people, join with them in a partnership for health - each doing what is best for health, for self and others. That is the meaning of prevention.

Dedicated to that noble purpose we can take not a small step but a big stride toward improving health for all.

For too long we have neglected prevention. Our health care dollars have been focussed too much on expensive technology, helpful perhaps to

a few but not doing what should be done for the people as a whole. Instead of working with all the people to advance health through prevention we have been spending too much on too few with too little benefit.

We must re-direct the tremendous resources that our nation has committed to health care - the thousands of fine institutions, the millions of well-prepared health workers, the billions of dollars we spend each year in the name of health - in a mighty partnership with the people themselves to advance health mainly through prevention.

I pledge that in its management of present health programs; in the development of national health insurance; in telling people "like it is" about health - that each person carries responsibility as well as do doctors, hospitals and government - my administration will lead the American peopleaway from the frustrations and failures in the health field to the great achievements that are now possible.

LB
P37

MONTEFIORE HOSPITAL AND MEDICAL CENTER

111 EAST 210TH STREET, BRONX NEW YORK 10467

OFFICE OF THE DIRECTOR

Telephone:
Area Code 212

September 7, 1976

Ms. Mary King
Carter Campaign
P.O. Box 1976
Atlanta, Georgia 30301

ATTENTION: DOMESTIC DEBATE--HEALTH ISSUES

Dear Mary:

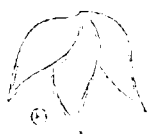
In addition to the revised memorandum on health manpower, preventive medicine and family health that you will be receiving this week, I thought that a briefer political analysis of several of the major points might be helpful in preparation for the domestic policy debate on September 23. I think the following points could be made and should be watched for:

1. Adequate financing for Ambulatory Care and Preventive Services is essential. Changes in the delivery system will not occur without concomitant changes in financing. Lower reimbursement rates for rural areas must be corrected and equalized with urban and suburban areas. Financial incentives must be provided to insure that basic preventive services such as immunizations and effective screening tests (hypertension, cervical cancer, etc.) are provided to all Americans and that the most efficient provider is reimbursed for providing them. This could certainly be proposed as one of the first "phases" of any health insurance proposal.

2. Public and Consumer Education in Preventive Medicine and Health Promotion. There has been no effective federal leadership in this area and a good political point can be made of this. The only HEW activities









of any generic significance (there are a few notable categorical exceptions like the National High Blood Pressure Education Program) are an ineffective Interdepartmental Panel on Health Education chaired by the Assistant Secretary for Health and a small Bureau of Health Education located in the CDC which has a very small budget (about $3 million) and no concerted major thrust.

The National Health Information and Promotion Act, recently passed by Congress, was opposed by the administration but signed anyway because of its inclusion in the overall CDC renewal and because of the likelihood of an override. It calls for significant sums of money for community demonstrations, research projects, and information programs relating to health promotion and prevention. It would also require the establishment of an office of Health Information and Promotion in HEW to develop the area as a major thrust. The administration appears to be doing only the minimum required by law: no additional funds have been requested as a FY '77 supplemental budget; the required office will be staffed by two professionals, and it appears to be business as usual with the focus still in the Bureau of Health Education at CDC. I think a political point could safely and effectively be made here--you might want to talk with Anne Somers, who is very much on top of it.

3. Health Manpower. In general this area is somewhat tricky politically since the administration has made some good efforts here and also the new bill, which is a Democratic effort of Paul Rogers and Ted

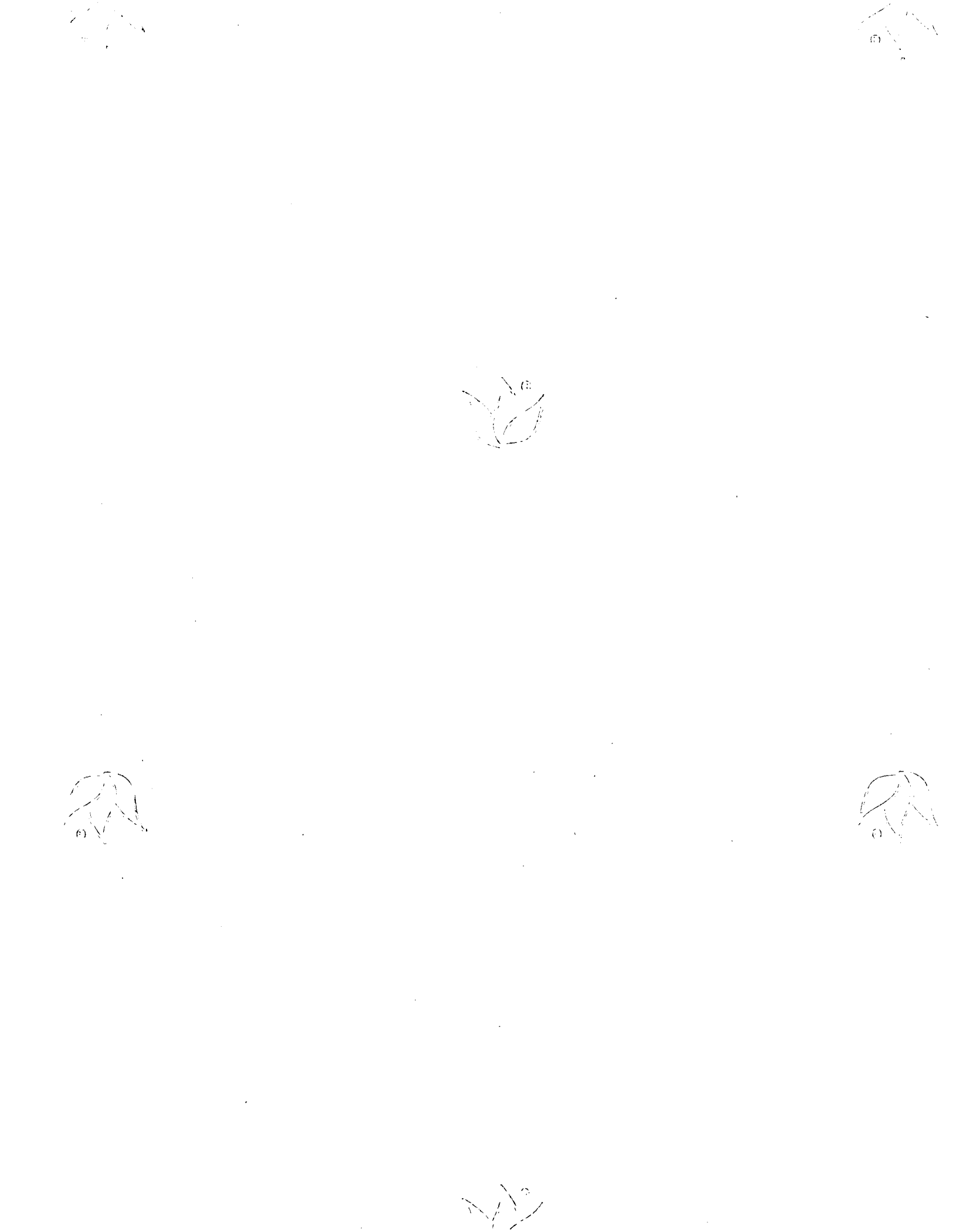
Kennedy, will probably be sent to the President for signature within the next several weeks. It probably will NOT be sent to the White House in time to force a signature or a veto prior to the debate. My guess is that Ford will sign it in any case, so some of the political advantage is lost. There are a number of manpower points, however, that can be made, which I think the candidate is concerned about and which have been failings of the administration--and in some cases, not emphasized enough in the bill as reported from conference.

a. Total Physician Supply and Foreign Medical Graduates. Whereas the administration has recently correctly argued that the total number of physicians is adequate, they have been opposed to addressing the issue of foreign medical graduates aggressively, even though between 40-50% of all new licenses each year are given to foreign graduates; even though the examinations for FMG licensure are considerably less stringent than for domestic graduates; and even though most Americans are concerned about the problem. The administration's position has been only that the examinations should be made similar. They have consciously chosen not to highlight the moral and ethical international "brain drain" effect. The conference bill contains provisions that begin to address this issue, although "brain drain" has not been emphasized, nor have physicians been eliminated from occupational immigration preference categories--a provision favored by Kennedy but eliminated by administration senators (Beall) in Senate markup. The overall posture should be that within the total supply the FMG component

should be significantly reduced for reasons of quality and brain drain and that any deficit should be made up by more American graduates trained with an emphasis on primary care, prevention, and service to rural and inner city areas. Obviously this should all be done in a way that does not discriminate arbitrarily against the FMG of quality who is not needed by his own country.

b. Geographic Maldistribution of Health Personnel. The Ford/Nixon administration has been relatively successful in the initiation of the National Health Service Corps and has supported a moderate expansion in the scholarship program that obligates students for such service. Some curriculum reform has also been initiated. What has been absolutely lacking, and is lacking in any significant way in the new manpower bill, is a major thrust to change admissions standards in schools of medicine and dentistry to focus on a percentage of individuals whose rural or inner city background, lower socioeconomic status, and personality make it probable that they naturally want to do "general practice" in underserved areas, rather than having to be obligated to do so. Most admissions committees choose candidates like themselves--urban specialists; but in a very few schools, aggressive efforts have begun to work. A Carter administration should stimulate and finance such further efforts as a national priority in health.

c. Minority representation in health professions schools. During the Ford/Nixon administration, the percentage of ethnic minorities in medical schools has not only fallen short of the goals, but has



been slipping backward. Out of a total health manpower budget of $600 million in FY '75, only $15 million was devoted to this problem. Many of the programs funded were "refresher" courses that are simply too simple a solution to a very complex problem. The answer is early college identification of minority students who are highly likely to succeed in a health profession and provision to them of financial support, counselling and careful preparation and follow-up both in college and in professional schools.

d. Excess Physician Specialists. This is a very complex problem that has been the major problem area in getting a new health manpower bill over the last three years. The administration favors a national study commission plus more support for family practice and general pediatrics and general internal medicine, which are good. The new manpower bill also requires medical schools that receive capitation payments to guarantee that the residency programs affiliated with them train a certain percentage of generalists. This is also appropriate, but somewhat cumbersome since the schools have little direct control over what the hospitals do. The most effective approach would be to fix national targets for numbers in each specialty, exert strong influence on those in oversupply to keep constant or cut back, and make funds available to teaching hospitals to make sure that the new positions required by the coming increase in total physicians are established primarily in the general categories. Much less support would be required for this purpose if the health insurance program supported primary care ambulatory services.

4. Health Services Research and Health Care Managers and Planners.

With costs of health care being out of control, very little attention is being paid to developing new methods of health care delivery and management that will help cut costs and improve quality. More resources and a new direction and thrust for these areas are essential and not that expensive. At the same time, there are not enough managers and planners with specific skills to help guide the system to cut costs and improve services. Programs in schools of public health and health care administration must be quantitatively and qualitatively increased.

5. Health Care as an Integral Part of Strengthening the Family Unit.

Other factors such as employment and education are obviously more important than health in this area. A number of health-related points can clearly contribute to this thrust however.

a. Increased production of family-oriented physicians, nurses and social workers who can provide a single integrated locus of care for the interrelated health needs of the whole family.

b. Increased use of supportive persons and services such as homemakers and visiting nurses to help families to cope with longterm illnesses and disabilities to keep the family together and reduce institutionalization.

c. Teaching and permitting family members who are available to provide appropriate parts of institutional care, e.g., feeding and simple nursing in the hospital.

d. Training of health professionals in psychosocial problems of families.

e. Increased availability and utilization of family planning techniques







as well as amniocentesis.

f. Public education in schools regarding basic preventive medicine and health promotion for the family, as well as responsibilities and realities of being a spouse, a parent and a child.

I hope these notes are helpful. Please let me know if anything else is required.

Sincerely,

David A. Kindig, M.D.
Director

DAK:cb

cc: Stuart Eisenstadt
Jack Watson
Ruth Hanft

January 30, 1976

American Academy of Child Psychiatry

To Committee
2/26/76

TESTIMONY OF THE AMERICAN ACADEMY OF CHILD PSYCHIATRY

BEFORE THE LIAISON GROUP TASK FORCE ON NATIONAL HEALTH INSURANCE

To: Bob Havely
From: Louise Weiner
See: Pages 4-5 for classification of those mentally ill children who should be covered under a National Health Insurance program. Pages 7-11 for cost approximations.

January 30, 1976

TESTIMONY OF THE AMERICAN ACADEMY OF CHILD PSYCHIATRY

BEFORE THE LIAISON GROUP TASK FORCE ON NATIONAL HEALTH INSURANCE

The prospect of having improved mental health services to Americans through a mechanism such as National Health Insurance is a challenging prospect. There are many issues involved, and child psychiatrists have strong opinions on many of these. Our principle and most natural concern lies with coverage for children, and this will be our main topic.

Is it necessary to talk separately about children? Should children have a different type of coverage from adults? The answer is that in some important ways children need different types of service from adults and do require separate consideration. Let us begin, though, with what the American Academy of Child Psychiatry sees as a basic principle regarding National Health Insurance which applies to both adults and children. We feel there should be equal coverage for mental health services under such an insurance program. By this is meant that there should be no more restrictions on services for mental and emotional disorders than on services for physical disease. Assuming that under National Health Insurance there will be comprehensive coverage for physical disorders, we would under the principle of equal coverage expect in like manner comprehensive coverage for mental health services.

Now let us shift to children. There is a tendency on the part of mental health professionals who work only with adults to assume that programs which are good for adults will be appropriate for children. Again we emphasize that there are important differences. Basic to some of these differences are the following features:

1. Mental illness in a child not only impairs functioning, as in adults, but it does more. It also hampers the child's emotional development. Treatment of emotional disorders in children must restore functioning, as in adults, but also hand in hand with this must go restoration of lagging development. Take the case of a neurotic child of seven who has been operating in most areas of his functioning no better than a four year old level. It is not enough that he should be relieved of his neurotic symptoms. His treatment must also enable him to catch up with his peers so that he functions as a seven year old generally.

2. Children are more fragile than adults, more vulnerable to stress and far more susceptable to emotional injury than is true for adults. This must be taken into account in a treatment program for children.

3. The dependency of children makes the environmental factors that surround them far more critical in planning service delivery. Thus, work with day care settings, with schools, and with families are <u>necessary</u> factors all through childhood.

4. The disturbed child who goes untreated often faces a far longer period of more profound disability than is true of emotional disorders later in life.

Because of the uniqueness of the mental health needs of children, the methods of intervention are different, requiring differences in diagnostic methods, in treatment techniques, in the nature of institutional arrangements, in the degree and quality of the family involvement necessary, and in the training of clinicians. As a result of the differences treatment for children must sometimes be of longer duration, especially in in-patient settings. It may require the utilization of a large number of highly trained specialists: psychiatrists, psychologists, social workers, special

education teachers, child care workers, speech therapists, recreational therapists, etc. In order to meet the mental health needs of all these children, the spectrum of services necessary requires inclusion of a number of different types of facilities. In addition to the usual out-patient services the following are important: day treatment with special education classes, therapeutic nursery schools, therapeutic boarding schools, group homes, residential treatment centers and hospital care.

Many services which are beneficial for the mental health of the child are difficult to categorize as to whether they are therapeutic, educational or supportive. When a social worker helps a chaotic family organize its affairs, is this therapeutic? When a special education teacher helps the child who confuses right and left learn to read in spite of this handicap, is this therapeutic? When a mental health counselor in a regular school helps a teacher cope with a troubled child through support and recommendations for handling, is it therapeutic? In a sense all of these are therapeutic. Should everything therapeutic in this sense be covered by National Health Insurance? Much confusion can arise as one attempts to draw a line among helpful services to children and their families to divide those that should be covered under National Health Insurance from those which are better funded in more traditional ways. The following is an attempt to clarify this matter. The key to differentiation lies in the degree of the psychiatric disability of the child. The range of psychiatric disabilities together with appropriate types of intervention may be categorized as follows:

In the first group are vulnerable or "at risk" children, who do not have obvious psychological dysfunction. They have other disabilities often of a chronic character, or they are in family or social settings that

education teachers, child care workers, speech therapists, recreational therapists, etc. In order to meet the mental health needs of all these children, the spectrum of services necessary requires inclusion of a number of different types of facilities. In addition to the usual out-patient services the following are important: day treatment with special education classes, therapeutic nursery schools, therapeutic boarding schools, group homes, residential treatment centers and hospital care.

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In the first group are vulnerable or "at risk" children, who do not have obvious psychological dysfunction. They have other disabilities often of a chronic character, or they are in family or social settings that

require intervention to prevent the development of psychiatric disorder. Some examples of such "at risk" children are the many youngsters with chronic physical disabilities such as blindness, deafness, congenital abnormalities, and the like. Other examples are children reared in conditions of severe deprivation; children caught up in major natural disasters; children involved in serious parental problems such as alcoholism or bitter custody battles, or loss of a parent through death, desertion or chronic illness and so forth. These children comprise a very large population group and often require intensive and ongoing social interventions to preserve healthy growth and to diminish the need for direct psychiatric services later. Such social services would normally be provided through mechanisms other than National Health Insurance.

Then there are the children with minor and transient difficulties involving social and emotional elements. These youngsters can usually be managed without psychiatric diagnosis or treatment. They require help from agencies or social institutions such as schools, churches, Big Brothers, visiting nurses and the like. Psychiatric consultation to these agencies and institutions is a valuable source of mental health expertise and should be seriously considered in weighing fundable mental health compensation. This might or might not be covered under National Health Insurance.

The following five categories of children with mental illness or disabilities ranging from mild to the most severe should definitely be covered by National Health Insurance.

1. Children with even mild degrees of retardation pose a special problem. These youngsters are already at risk, and even minor degrees of emotional difficulty will pose severe threat to functioning and development. Therefore, early use of psychiatric services is required by this group.

2. Children with evident symptoms of mental or emotional disorder require psychiatric diagnosis and treatment. Such diagnostic studies include psychiatric interview, psychological testing and family interviews by psychiatrist or social worker. Special educational study and neurological examination may also be necessary. The large majority of such children will be adequately served by outpatient treatment. Some will need only diagnostic study and evaluation follow-up interviews. Some may require further regular treatment for three to six months. Others may require intensive outpatient treatment up to three to four times a week for a period of several years. The techniques of the required outpatient treatment will vary depending on the individual patient; they may include group, individual, and/or family psychotherapy, drug treatment, therapeutic schooling, and others.

3. A smaller group of children with established psychiatric diagnoses of mental or emotional disorder will require additional psychiatric intervention in the form of day hospitalization or day treatment, or therapeutic group homes.

4. A small number of adolescent patients may require brief hospitalization or residential treatment to deal with an episode of transient severe mental difficulty. Following discharge, a further period of outpatient treatment will be required.

5. The most disturbed group of children with obvious severe psychiatric disorders of long-standing duration will require highly structured, long-term intensive treatment environments. Depending on the individual patient, either a hospital or residential treatment setting will be necessary for adequate care and treatment. It is important to emphasize here that duration of <u>in</u>-patient treatment for <u>children</u> is of a different magnitude from <u>in</u>-patient treatment of <u>adults</u>. Instead of a few days to a few months,

it is apt to be one to three years. Children in need of this last resort type of treatment need to be removed from home to live in a specially devised environment which provides therapeutic interaction through all the waking hours. They must live in this environment long enough that they can catch up in their lagging development so that they can be returned home. The duration of in-patient treatment for adolescents as apposed to younger children is apt to be more like the length of that for adults.

Adequate psychiatric treatment for children must include two other features which differ from adults. To better understand and help the child, the psychiatrist and parents must work together. It is essential for the parents to understand their contribution to the child's problems, so they can correct these deficiencies, and in addition, the parents must learn the art of managing the child at home. Coverage for therapeutic interviews and for counseling with members of the family household, particularly parents or parent surrogates, must be provided.

In treatment of a mentally ill child direct psychiatric interviews and consultation by the child psychiatrist with teachers, juvenile court personnel, and other social agencies are often essential. The psychiatrist, for example, needs to know about the child's behavior in school and he/she may wish to make recommendations for the handling of the child by teachers. Reasonable coverage for such time consuming consultative services should be included in national health insurance.

Dr. Joseph Noshpitz and Dr. Dexter Bullard, Jr. of the American Academy of Child Psychiatry have studied the cost of providing America's children with good mental health services under National Health Insurance. Here follows their estimations:

Costs

Cost estimates are necessarily imprecise because of changing population figures, variable utilization rates, and changes in the costs of delivery of psychiatric services. At this time, the range of costs for various psychiatric services is approximately:

A.	Brief Outpatient Intervention		$ 300/3 mos.
B.	Intermediate Outpatient Treatment		$ 720/3 mos. $1440/6 mos.
C.	Intensive Outpatient Treatment		$4800-6400/ yr.
D.	Group Home or Professional Foster Placement		$9125/ yr.
E.	Intensive Day Treatment		$6000-12,000/200-day yr.
F.	Intensive Residential Treatment		$16,000-20,000/ yr.
G.	Hospitalization	Crisis: Long-term:	$2310-2940/ 21 days $39,000-52,000 / yr.

Cost Estimates

Based on the aforegoing estimates of costs for specified services, it is possible to estimate the cost of psychiatric services for children and adolescents in several ways. Two of the most useful are costs based on utilization estimates and costs based on need estimates. Utilization estimates provide the best estimations of cost which will be incurred at the inception of a program. Need estimates provide an estimation of ultimate costs if there is sufficient funding and full availability and utilization of services throughout the population. Both estimates will be presented here.

1. Utilization Estimates

The most global estimate of cost for child psychiatric care has taken the rough figure of 10% of total costs for mental illness which has been estimated in 1971 at 10.4 billions.[1] (1. Reference: Insurance for Mental Health: Report of the Work Group on Health Insurance NIMH, Nov. 1974, pg. 5). However, a breakdown of direct costs (op. cit. pg. 6) do not spell out the direct cost of child and adolescent psychiatric services. These 1971 figures do not include the rising cost of direct services, the factor of inflation and the increased utilization since 1971.

The following figures are based on utilization of psychiatric facilities in 1971-73. A 10% increase in utilization has been added as well as current (1975) costs for specific services with an inflation factor (1975-76) of approximately 10%. Some direct service costs have been estimated assuming a maximal use of available service. It is likely, therefore, that first year costs will be at or below the following utilization estimates.

I. Outpatient Care

A. Outpatient Clinic Care

Number of outpatient admissions - 391,000 (children and adolescents)

1. Brief interventions - 234,600 (60%) @ $300 per patient	70.4 million
2. Intermediate intervention - 146,625 (37.5%)	
3 months treatment - 78,200 (20%) @ $720 per patient	56.3 million
6 months treatment - 68,425 (17.5%) @ $1440 per patient	98.5 million
3. Intensive intervention - 9,775 (2.5%) @ $4800-$6400 per year	46.9 to 62.6 million
Total Outpatient Clinic Cost	272.1 to 287.8 million

B. Private Practitioners in Office Setting

1. 2,500 child psychiatrists Maximum one-half time in direct patient care - private office setting	96.0 million
(Estimates of costs of direct office services from child psychologists, child psychiatric social workers and child psychiatric nurses are not available but are probably in the range of 150-200 million)	200.0 million
Total Cost of Outpatient Office Practitioners	296.0 million
Total Outpatient Care	568.1 to 583.8 million

II. Inpatient Care (It is estimated that the increase in admissions equals the average decrease in length of stay so that total patient days remain approximately the same)

A. State and County Mental Hospitals

Episodes	26,300
Average length of stay	X 90 days
	2,367,000 patient days
Cost -	$100-$140/day
	236.7 million - 331.4 million

B. Private Mental Hospitals

Episodes	6,400	
Average length of stay	X 40 days	
	256,000 patient days	
Cost -	$100-$140/day	
	25.6 million	- 35.8 million

C. General Hospital Psychiatric Units

Episodes	44,100	
Average length of stay	X 15 days	
	661,500 patient days	
Cost -	$100-$140/day	
	66.2 million	- 92.6 million

D. Residential Treatment Centers

Episodes	11,100	
Average Length of Stay	1.5 years	
	16,650 patient years	
Cost per year	16,000-20,000	
	266.4 million	- 333.0 million

E. Community Mental Health Centers

Episodes	16,000	
Average Length of Stay	X 15 days	
	240,000	
Cost per day	$100 to $140	
	24.0 million	- 33.6 million
Total Inpatient Care	618.9 million	- 826.4 million
Cost of Outpatient Care	568.1 million	- 583.8 million
Cost of Inpatient Care	618.9 million	- 826.4 million
Total Cost	1187.0 million	- 1410.2 million

At the approximate cost of 1200-1400 million, the cost for each of the 30 million families with children living at home would be $40.00-$47.00 per family per year, or $3.33-$3.92 per month. The cost per person (220 million persons) would be $5.45-$6.36 per person per year.

2. Need Estimates

Children represent approximately 40% of the total population of 220,000,000 or 88,000,000. A rough estimate of the number of children with definable psychiatric disorder is 10% or 8,800.

Current utilization figures suggest that only 10% (880,000 children) of the population with definable disorders actually seek out and use psychiatric services in any one year. It is estimated that 85% (748,000) will be treated as outpatients and 15% (132,000) will require other more supervised settings, including inpatient treatment.

Using these estimates, it is possible to project a range of anticipated annual cost for mental health care for children and adolescents.

Outpatients: 748,000 children	Costs
Brief outpatient intervention - 50% of outpatients 374,000 children	$112,200,000
Intermediate outpatient treatment - 40% of outpatients - 299,200 children	
149,600 - one-half receive treatment for 3 mos.	$107,712,000
149,600 - one-half receive treatment for 6 mos.	$215,424,000
Intensive outpatient treatment - 10% of outpatients 74,800 children	$359,040,000 - $478,720,000
Total Outpatient Cost Range -	$794,376,000 - $914,056,000

Inpatients: 132,000 children	
Brief hospitalization (in addition to other treatments) 26,400 children	$60,984,000 - $77,616,000
Group Homes (35% of children who need inpatient care) 46,200 children	$421,575,000
Day Treatment (35% of children who need inpatient care) 46,200 children	$277,200,000 - $554,400,000
Residential Treatment (20% of children who need inpatient care) 26,400 children	$422,400,000 - $528,000,000

Hospital Treatment (5% of children who need inpatient care) 6,600 children	$257,400,000 - $343,200,000
Total Inpatient Cost Range	$1,439,559,000 -$1,924,791,000
Total Outpatient Cost Range	$ 794,376,000 -$ 914,056,000
Total Cost Range	$2,233,935,000 $2,838,847,000

At the approximate total cost of two to three billion dollars, for the 30 million families in the United States with children living at home, the cost for each family would be $66.67-$100.00 per year, or $5.56-$8.33 per month. The cost per person in the United States (220 million persons) would be $9.09 - $13.64 per person per year.

Finally, I wish to conclude with the American Academy of Child Psychiatry's position on mental health coverage in general for children and adults.

Coverage of all varieties of accepted, existing mental health services are necessary. A mode of treatment appropriate for one emotionally disturbed person may not be helpful to another. A pluralistic mental health service system is necessary to meet individual needs for care which would allow for the most appropriate and efficient treatment for the patient and prevent stagnation and rigidity in the development of mental health care.

The Academy is in opposition to positions which discriminate against private practice in favor of organized care settings. Private practice is frequently the most efficient and economical use of manpower. In organizational settings much efficiency is often lost through considerable effort spent for intra-staff communication and for administrative activities.

In the case of psychiatric disorders of a more than mild or transient nature, the American Academy of Child Psychiatry feels that there should be in-put by a physician. This should consist of participation in the initial evaluation followed by, if the physician feels it is indicated, continued collaboration throughout the treatment process. National Health Insurance

should cover services rendered by non-medical mental health professionals, when authorized or supervised by a physician.

When the treatment is provided in one of the facilities listed above, such as residential treatment centers, group homes, etc., these should be covered by National Health Insurance as long as the services are authorized by, supervised by, and conducted in collaboration with a physician.

Participation by a physician is indicated to insure that organic factors in the case are properly evaluated and so that appropriate consideration be given to inclusion of medical therapy such as drugs in the overall treatment plan for the patient.

The patient and his family also must have the right to choose treatment in any of the various service delivery systems, e.g., private practice, community mental health centers, health maintenance organizations, etc. Freedom of choice prevents the entrenchment of a single form of service delivery and encourages innovative patterns of care.

In any third party payment system, co-insurance and deductibles should not interfere with the provision of basic benefits and should be related to the patient's capacity to pay.

The patient must feel comfortable about seeking help for mental illness. It is essential for his own protection that all information about the patient's emotional health be kept confidential. People will not seek mental health assistance if they are fearful of the violation of their privacy.

Finally, the American Academy of Child Psychiatry strongly supports the concept of utilization and peer review. The legally constituted Professional Standards Review Organization is one means of assuring proper utilization and quality of services provided. To prevent abuses of coverage

such review mechanisms should be an integral part of a National Health Insurance program.

The American Academy of Child Psychiatry is well aware of the divergence in views among Liaison Group members in some of these matters. We hope to maximize the areas of unanimity, as we go before Congress.

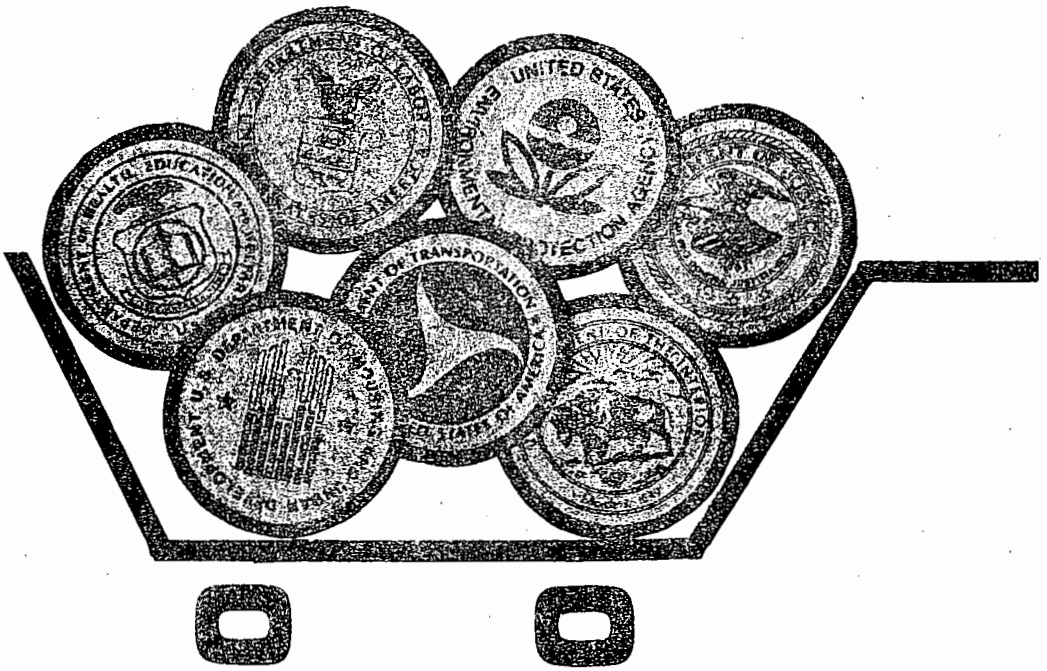
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RED TAPE IN THE FEDERAL SUPERMARKET



The Northwest Federal Regional Council

Northwest Federal Regional Council

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June 1, 1976

To the Reader:

Officials at all levels of government in this country, whether they are elected or hired, work daily with the growing complexity of the governmental system. Most work hard at their own part of that system, but few have the time and the authority to analyze the cumulative effects of the decisions being made within the many different elements of the governmental system. There is a growing awareness that these cumulative effects are beginning to impair the fundamental working relationships between the Federal, State and local governments in the United States.

The Federal Regional Councils were established to deal with precisely this type of intergovernmental issue. That is why the Northwest Federal Regional Council has chosen to perform a preliminary study of problems in the intergovernmental system. This study focuses on planning because it is planning which suffers the most whenever administrative systems are in trouble.

The study looks at human services programs under seven Federal departments, programs in which State and local governments are the grantees. This is not meant to be a definitive study, but rather an exploratory one which may point the way for further analysis and hopefully reforms. The programs studied were not chosen as being the most in need of reform, but only because it was necessary to start somewhere.

The problems identified here are very real, very specific problems plaguing the intergovernmental system. They may be resolved through major reforms such as Federal block grants, but they can also be addressed through more limited changes in statutes, regulations, and practices. We hope this study will help to focus generalized concerns about "Federal red tape" onto specific problems. Only then can these problems be successfully addressed by any mechanism.

Because of its controversial nature and detailed information, this report is being given an initial circulation in draft form. The Northwest Federal Regional Council welcomes your comments and suggestions.

Sincerely,

Bernard E. Kelly
Chairman

FOREWORD

THE FEDERAL SUPERMARKET

The Federal grant-in-aid system is often compared to a giant supermarket, and in many respects that is a good analogy. However, every analogy is by nature imperfect and it is unfair to point out how two things appear similar and then to criticize them for not being exactly alike.

The Federal government is of course not a supermarket, and no one would suggest that it should be; but the analogy reveals many complexities of the Federal grant-in-aid system.

The Federal government markets about 1100 different commodities called "programs." It marks and shelves them every year in the form of funds for which various "shoppers" may apply: states, local governments, profit-making and non-profit organizations; colleges and universities, Indian tribes, and citizens in many groups and stations. The supermarket is called the Federal grant-in-aid system.

States and local governments are among the biggest shoppers. They buy roughly half of the products, both in terms of commodity items (programs) and Federal dollars consumed.

The store is managed by the "feds." Some feds are elected by the shoppers; most are not. Only experts can usually tell which store policies are set by the elected, which by the appointed feds. Hundreds of pages of new and revised store policies are published every month. Only an expert can be sure of finding every store policy on any one commodity at any given time. Once they find them, the experts often disagree on what the written policies mean. Not that it's hopeless; shoppers rely a lot on habit and tradition, and keep hiring more and more experts to interpret the policies.

Basically, shoppers set out to shop for what they need, usually prepared to buy whatever comes close to their specifications. There are the staples, called formula or entitlement grants, which every state shopper needs; and there are the specials, called project or discretionary grants, which are often very good buys but have a limited shelf life.

The supply of both staples and specials changes year to year, depending on what the feds think it is important to stock. The feds go through various stocking exercises called budgeting, authorizing, and appropriations each year. Stocking is a complex business. The shopper never knows for sure what will be on the shelf until long after he gets his money and shopping list from his parent, the state or local legislature. The shopper often gets in trouble with his parent when he guesses wrong about what's going to show up on the Federal shelf. (This is called the Problem of Anticipating Federal Funds.)

Shopping is not just a Saturday morning trip. There are only certain times of the year when certain commodities may be purchased. These are marked by due dates for the required state/local plans or applications. These due dates vary by commodity and often change year to year. Unfortunately, there's no one place where all these due dates are posted. Even if the

shopper reads the shoppers bulletin, called the Federal Register, every day, he may miss the due date and arrive too late for the product he really wants. Shoppers worry a lot about this and join shopper associations to keep up with rumors of due dates. (This is called the Problem of Due Dates.)

Even if a shopper knows when to shop, he may not know where. There are several outlets to the Federal supermarket: a central warehouse in Washington, D.C., and ten regional stores across the country, with many different "departments" at each location. Some commodities are sold centrally, some regionally, some in both places. Supply is sometimes done in one place, billing in another. There is no published shoppers guide which tells where to look; shoppers can usually--but not always--find commodities where they were last year. Smart shoppers make a lot of phone calls before leaving for the store, and even their fingers get tired of walking through the yellow pages. (This is called the Problem of the Locus of Federal Responsibilities.)

Prices are another problem. These are generally called "matching rates." They vary a lot between programs for reasons not apparent to the shopper, and fluctuate year to year. Sometimes the feds take one look at the shopper, or ask what he intends to do with the product, and proceed to charge him a different price. Some programs have as many as four variable prices, depending on "circumstances." Quite often feds won't sell the shopper a product unless he buys at least as much as last year--they call it "maintenance of effort." And finally, there are quotas, called allocations, which allow certain shoppers to buy only certain amounts. Obviously, these things often get shoppers in trouble with their parents who want certain things but who also like good deals and above all don't want the shopper to overspend. Shoppers call their parents about these problems, but that's hard if one's parent isn't home (legislature isn't in session). (All this is called the Problem of Federal Funding Rules.)

Also, the feds are very protective of their products. They simply won't sell the products to state and local shoppers unless the shoppers convince the feds that they will handle and preserve the goods properly. While a certain amount of this is understandable, the feds sometimes even tell the shoppers how to design their kitchen, where to locate the stove and refrigerator, and exactly who to consult in selecting the best recipe for each meal. The feds are so serious about these things that they give the shoppers bags full of gratuitious advice. (These are called the Problems of Geographic Districts, Organizational Structures, and Advisory Groups.)

This is not to suggest that either the elected or appointed feds don't mean well. They have a separate commodity for just about every need anyone can identify. The trouble is, every package comes complete with instructions not only as to how it is to be served, but who is to be served by it. This makes it very difficult for shoppers to do meal planning and assure balanced diets at home. Some commodities are not even compatible. (This is called the Problem of Federal Eligibility and Services Specifications.)

It's not that either the elected or appointed feds are opposed to meal planning and balanced diets. On the contrary, there are big signs posted by the supermarket door warning shoppers to always PLAN and COORDINATE whatever they buy. Most shoppers chuckle at these signs. They would like to plan and coordinate, and it would be nice if they could really figure out the needs at home and shop judiciously at the Federal supermarket. Unfortunately, what with due dates and changing prices and keeping up with store policies and anticipating what the feds will stock and finding the right store and convincing the feds they will keep the rules and convincing their parents that they know how to shop--there just isn't a lot of time or freedom to really plan very much. (These problems are called The Documentation Blizzard and Inconsistent Federal Planning Requirements.)

Sometimes state and local government shoppers get very frustrated about this and think that maybe they'd be better off if they didn't shop at the store at all. But usually by the time they reach this point, they have so many experts and other mouths to feed that they have no choice but to return to the Federal supermarket again and again.

A few of the shoppers are downright optimistic. They harbor the hope that someday the feds will ease up a little and there will be time to use all those state/local experts as <u>planners</u> rather than interpreters. There is a small secret group of shoppers who have dedicated themselves to promoting this change. Rumor has it that they have even converted a few feds....

DRAFT

RED TAPE IN THE

FEDERAL SUPERMARKET

A Study of Federal Constraints
to Planning by State and Local
Government Grantees Under
Federal Grant-In-Aid Programs

NORTHWEST FEDERAL REGIONAL COUNCIL
June, 1976

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PART I

INTRODUCTION

The concern of state and local government officials with the number and complexity of federal mandates in intergovernmental service programs is becoming increasingly visible as elected officials and program managers face tight budgets and try to focus their resources on the greatest needs of their citizens. In many cases, they are finding it increasingly difficult to implement their own policies, priorities, and ideas regarding efficient service delivery systems.

The frustration of elected officials was expressed quite clearly at the recent White House Public Forum in Los Angeles:

Los Angeles (UPI) - Vice President Nelson Rockefeller, winding up the last of six nationwide public meetings, said Tuesday the American people have given him a message to take back to Washington.
"Everwhere we went, we found the American people fed up with government bureaucracy and red tape," Rockefeller told reporters near the end of the White House Public Forum on Domestic Policy.
"If there's one message we've gotten, that's it."

Washington Gov. Daniel Evans, one of four Western governors at the meeting, voiced frustration with spiraling Catch-22-type regulations in remarks that Rockefeller described as "a brilliant insight" and the most succont" he had ever heard on the subject of federal-state relations.
"It's time for a thorough house cleaning," Evans insisted at one point, "or else our aid to those who need help the most is simply going to founder.
"It's time the federal government set performance standards for the states and stopped issuing how-to-do-it guidelines and booklets.
"In other words, in blunt terms, get offour backs. We can do many jobs better while accepting fewer federal dollars if you'll just give us the administrative flexibility."

"The way the Feds cut red tape is lengthwise!"

Governor Raul Castro - Arizona
L A White House Public Forum, December, 1975

The history of government in the United States is necessarily a history of three types of government: local, state, and Federal. Any study which proposes to analyze the relationship between these levels of government is immediately subject to multiple points of view and cast in an arena of political and philosophical debate.

This study of the grants-in-aid by which Federal funds flow to and through state and local governments is no exception. For that reason, a few basic assumptions must be clarified.

The grant-in-aid system implies expenditure of Federal tax dollars and accountability for that expenditure: to the taxpayer, to the legislative body which allocates the funds, and to the service organization which passes the funds to citizens in the form of aid or services. Federal assistance implies Federal accountability.

The grant-in-aid system also implies state or local administrators. This system provides a role to state/local governments in the administration of the Federal funds. State/local administration therefore includes some degree of administrative prerogative for state/local governments.

The continuing, volatile, and most difficult issue of the Federal grant-in-aid system is the BALANCE of Federal accountability demands and state/local administrative prerogatives.

The complaint of "too much Federal red tape," therefore, when voiced by state and local government officials, is a call for a change in the balance of Federal demands and state/local prerogatives. That may be a call for a basic shift of power and responsibility, and even for a shift in the source of funding, e.g., assumption of full responsibility for administering public welfare programs to the Federal government. Alternatively, the call may reflect state/local desire to have full freedom to expend Federal dollars without collecting the taxes, e.g., in Federal Revenue Sharing.

A third possibility is that the"red tape" complaint may signify no real disagreement over the basic roles of Federal, state, and local partners, but rather a conviction that current Federal rules do not allow state/local governments to most efficiently and effectively perform their part of the partnership, the delivery of the aid or services.

It should be possible to study the factual basis for state/local charges of "Federal red tape" without preselecting the reform necessary to correct the problem. That is what this study tries to do.

Therefore, while this study may seem to provide justification for one or another type of intergovernmental reform, it is not directed to that end. The study is intended to neither support nor decry full Federal administration, revenue sharing, block grants, or other reforms.

GENESIS OF THIS STUDY

The Northwest Federal Regional Council Workplan for FY1976 called for a study of the relationship of Federal planning requirements to state and local government grantees. The study was conceived as an effort to verify the accuracy of the common complaint of state/local government grantees in Region X about the burden of "Federal red tape," particularly as directed at Federal planning requirements. (Appendix II)

Early in FY 1976 the General Accounting Office published a report: Fundamental Changes Are Needed in Federal Assistance to State and Local Governments. The report identifies an array of problems which state and local governments face when trying to obtain and use Federal assistance, and attributes these problems to the proliferation of Federal programs and the fragmentation of organizational responsibilities: (1) problems in identifying Federal assistance, (2) problems in applying for and administering Federal assistance programs, and (3) problems in meeting needs with a fragmented delivery system.

Between August, 1975, and March, 1976, the Region X Office of the Department of Health, Education, and Welfare conducted on behalf of HEW nationwide, a National Management Planning Study covering the largest HEW programs for which State and local governments are the grantees -- some 54 programs accounting for over 90% of the annual HEW funding to such grantees.

In November, 1975, the Northwest Federal Regional Council agreed to conduct a limited planning study across Federal Departments and programs, utilizing some of the research tools developed by HEW in its questionnaire, and voluntarily identified a small number of DOI, DOL, DOT, EPA, HUD, and LEAA programs in which the questionnaire was completed. This is the report of that study.

The limited number of programs included in the NWFRC study and the limited nature of the data-collection tool used do not allow hard conclusions and recommendations for change in the conduct of intergovernemtal grant-in-aid programs across the various Federal Departments. Rather, the NWFRC study documents that many of the problems experienced by state and local governments with HEW programs are common to other Federal programs as well. The NWFRC hopes that this study will be useful in focusing the generalized concerns about "Federal red tape" on specific problems which are amenable to further government-wide analysis and reform.

The FRC study did not include additional discussions with state or local government officials, and was limited to completion of a single, rather extensive quesionnaire by representatives of each of the programs studied. That questionnaire is included as Appendix III.

PART II

PART II

PROBLEMS WITH THE FEDERAL SYSTEM WHICH AFFECT PLANNING

The HEW Management Planning Study identifies a number of problems identified by state and local government grantees, and verifies that the basis for these problems exists in Federal statutes and regulations.

The Federal Regional Council (FRC) study analyzes a cross sample of other Federal planning programs and verifies that most of the problems identified are not limited to HEW programs. Where this is true, an extension of the study to a broader array of Federal programs is suggested, and possible outcomes and recommendations are discussed.

This part of the report presents each of these problems in turn:

1. The Documentation Blizzard
2. Inconsistent Federal Planning Requirements
3. Federal Eligibility and Services Specifications
4. Organizational Requirements
5. Geographic Districting Requirements
6. Advisory Group Requirements
7. Federal Funding Rules
8. Locus of Federal Responsibilities
9. Due Dates
10. Anticipating Federal Resources

PROBLEM # 1: THE DOCUMENTATION BLIZZARD

"Comprehensive human resources planning and plans do not exist because state "plans" serve the purpose of acquiring Federal and state categorical monies for programs. The plans consist of only what is necessary according to laws or regulations...Plan ingredients nearly always cater to Congressional and Federal and state agency wishes, not sub-state needs and priorities expressed through local plans and/or consistent with local input."

("A Compendium of Human Resources Planning Processes in the State of Washington", Vol. IV, October, 1975, p. 50)

This section explains (1) whether the programs studied are formula/entitlement or project discretionary grant programs, (2) whether grantees may be state governments, local governments, or other organizations, (3) what type of primary grant documents are utilized, and how many are required foreach program.

HEW PROGRAMS

HEW requires every state receiving funds under its 46 formula grant programs to submit or annually update 24 separate state plans and 8 separate applications or agreements. States have an option to submit combined state plans for:

Crippled Children's Services	(13.211) and
Maternal and Child Health	(13.232)

for:

Rehabilitation	(13.624)
Developmental Disabilities Basic Support	(13.630)

and, under the General Education Provisions Act of 1974, for 20 education programs:

13.400	Adult Education
13.427-31	Educationally Deprived Children (5 programs)
13.449	Handicapped School and Preschool Programs
13.480	School Library Resources
13.483	Strengthening Instruction
13.486	Strengthening State Departments
13.493-95 & 498-502	Vocational Education (8 programs)
13.519	Supplementary Educational Centers
13.543	Strengthening State and local Ed. Agencies - P&E

By employing all options to submit consolidated plans, a state may reduce the number of required plans from 24 to 14; however, interviews with state managers indicated that in their view, the consolidated plans often represent little more than a stapling activity.

Analysis of legislation, regulations, and plan samples shows that the words "Plan," "Application" and "Agreement" have no standard definitions and are used inconsistently. While formula grant programs usually require "plans" and project grant programs usually require applications, this is not always true. Some programs require both and some formula programs require "applications" instead of "plans."

Grantees in major HEW programs are almost always states, although local governments, school districts, and Indian tribes comprise sub-grantees in many programs.

While many programs use preprinted forms as part of their required documents, only 7 of the 54 programs studied now rely substantially on preprints alone:

13.478	SAFA Maintenance and Operation
13.548	Grants to States for Student Incentives
13.609	Aging Programs
13.624	Rehabilitation Basic Support
13.630	Developmental Disability Basic Support
13.714	Medicaid
13.789	Work Incentive Program

At least half of the preprints now in use require such major state decisions and/or supplementary documentation that their completion can hardly be construed as simple. Where preprints are used, they are sometimes criticized by state officials as not representing a sufficient report of the planning function carried out by designated planning agencies (Human Social Services Planning Study, Minnesota, 1975, page 49).

The HEW study collected some limited data on staff time required to produce "plans" at the state level. Interviewee responses across the various programs show that the average state uses 26 full time staff to complete the 24 required state plans. This would amount to 1300 full-time state staff, or the equivalent, nationwide. This would not include the staff preparing up to 96 annual HEW project grant applications in each state.

OTHER PROGRAMS

The HEW study was extended to include 10 other programs in six other departments: five formula/entitlement programs, three project/discretionary grant programs, and two which have both formula and project components. Three programs serve state grantees only; one, local government grantees only; and six, state and local governments as well as other entities such as Indian tribes.

For these ten programs each state participant annually submits at least ten state plans or applications; and each local government participant, six local plans or applications. No count was attempted of the total number of annual primary grant documents which this represents nationwide. Various combinations of state and local plans and applications are required in individual programs.

None of these programs uses a plan or application format which is totally "pre-printed," a completion or check-off form. Three programs use formats which are generally narrative in nature; the rest use some combination of narrative and pre-print format in their plans and applications. No attempt was made to analyze state and local staff time spent on these documents.

DISCUSSION

Extension of the HEW study to a sample of other Federal programs suggests that the wide array of primary grant documents labled "plans" and "applications" required of state and local governments is characteristic of other Federal programs as well. The number of such documents appears to relate to the number of Federal programs for which state and local governments are eligible.

The number and variety of such documents and the manpower they consume could well be a serious intergovernmental issue; and therefore simplification, combination, or standardization of primary grant documents, even in the absence of more sweeping reforms, might constitute a significant intergovernmental advance.

DOCUMENTS REQUIRED OF GRANTEES

HEW

	Plan	Application or Agreement
NHPRDA	X	
13.210	X	
13.211	X[1]	
13.217*		X
13.224*		X
13.232	X[1]	
13.257	X	
13.269	X	
13.286	X	X
13.400	X[2]	X
13.403*		X
13.408, 464, 465	X	
13.427-431, 512	X[2]	X[2]
13.433*		X
13.449	X[2]	X[2]
13.453	NONE	NONE
13.455		X
13.478		X
13.480	X[2]	X[2]
13.483	X[2]	X[2]
13.486	X[2]	X[2]
13.491		X
13.493-495, 498-502	X[2]	X[2]
13.519	X[2]	X[2]
13.525*		X LOCAL
13.534		X LOCAL
13.542	X[2]	X[2]
13.548		X
13.550		X
13.600*		X LOCAL
13.609	X	
13.624	X[3]	
13.626*		X
13.630	X[3]	
13.707	X	
13.714	X	
13.754	X	
13.761, 724	X	
13.748	X	
	14 Minimum	8 State Applications - Formula Programs
	24 Maximum	5 State Applications - Project Programs
		3 Local Applications - Project Programs

* Project Grant Programs

[1] Optional consolidation State Plan

[2] Required single general application. Optional consolidated plan for two or more

[3] Optional consolidated State Plan

DOCUMENTS REQUIRED OF GRANTEES	HUD		DOI	LEAA		DOL	DOT	EPA	
	14.203	14.218	15.605 & 611	16.500	16.502	17.232	20.103	66.426	66.600
Formula or Project Grant Program	P	F P	F	F	F	F	P	P	F P
Grantees: State/Local Government/ Other	S L O	S L O	S	S L O	S L O	S L O	S L O	L	S
Basic Document Required:									
State plan or plan update	X			X	X	X			X
Local plan or plan update						X		X	
State application	X		X		X		X		X
Local application		X(2)					X	X	
This Document Is:									
Pre-print									
Narrative	X				X				X
Both		X	X	X		X	X	X	

PROBLEM # 2: INCONSISTENT FEDERAL PLANNING REQUIREMENTS

"Nearly all of the planning documents are made up of material included to accommodate Federal and state reporting requirements and, as such, serve only as applications for continued funding. There is little effort to relate accumulated information to program budgeting on a systematic basis or to perform analysis for programmatic and organizational problem-solving."

("Human Services Planning Study," Minnesota State Planning Agency, July 1975, page 49.)

One element of the state/local complaint about "Federal red tape" is the suggestion, as quoted above, that Federally-required "plans" are not really plans, but compliance documents, and are useless to state/local decision-makers. The HEW study sought to address this issue by asking state/local administrators what they would find useful in decision-making.

In describing the basic decision-making functions necessary to employ the most efficient use of resources to meet identified community need, the state/local interviewees commonly identified the following (although many different lables were used, the "order" differed somewhat, and some functions were split or combined):

1. Need Assessment
2. Resource Assessment
3. Analysis of Resources against Need
4. Setting of Priorities and Objectives
5. Allocation of Resources
6. Prioritization of Unmet Needs
7. Evaluation of Program Success

This concept of planning simply means that anyone attempting to plan a program of service to people would normally identify a need, figure out what resources are availble to meet it, set priorities and objectives, allocate resources so as to achieve as many objectives as possible, and evaluate the program's success and the needs left unmet.

The term used in the HEW study for this process is "Management Planning." The product of such a process would describe what services are to be given, in what order, with what resources, to whom, and where.

The issue in this section, therefore, has to do with Federal requirements for "Management Planning" and the uses to which Federal documents are put at the Federal, state, and local levels.

HEW PROGRAMS

An analysis of the statutory and regulatory requirements for the seven elements of management planning, as identified above, shows the following:

1. Many HEW statutes and regulations seem to require a number of the seven elements of management planning.

2. Such requirements are markedly inconsistent among programs.

3. Regulatory vs. statutory requirements are inconsistent within programs. Indeed, this study found not a single program in which the statute and the regulations appeared to uniformly specify the same management planning requirements.

(See chart at end of this section.)

Further analysis of a small sample of the HEW required plans themselves showed that:

1. Some management planning is in evidence in the Federally-required documents.

2. This bears little apparent relationship to the regulatory and statutory requirements.

2. Only one-fifth of the documents reviewed show any substantial evidence of management planning, and none of these could be construed as showing substantive evidence of all seven basic management planning functions.

Granting the judgmental and limited nature of this review of plan documents, the conclusions accord with the opinions of Federal, state, and local interviewees:

- 70% of the state and local interviewees stated that the Federally-required documents are of little management value to them.

- 75% of the Federal interviewees said that the "plans" are inadequate for evaluating the program priorities set by grantees.

The HEW study concluded that the plans produced under inconsistent Federal planning requirements are of marginal utility to management decision-making, but do serve a compliance and monitoring function, though not usually as the sole basis for monitoring grantee performance.

OTHER PROGRAMS

Analysis of the laws and regulations of the other Federal programs studied reveals an inconsistency in planning specifications similar to that observed in the HEW study. A chart of this analysis of other programs follows at the end of this section. Planning requirements are seen to be inconsistent between programs and Departments, and between statutory and regulatory specifications.

No interviews were conducted to indicate how useful these documents are perceived to be for decision-making purposes, nor were any samples of the documents themselves analyzed. Federal program officials indicated that, as in HEW, the documents serve a heavy monitoring and compliance function, although reliance on the documents in this function would appear to vary considerably between Departments.

In half of the programs (compared with 25% in HEW), the documents are perceived by Federal administrators as an adequate basis on which to evaluate grantee priorities. In the other half of the programs, either the grantee priorities are not evaluated at all, or else such evaluation is made upon some basis other than the primary plans or applications submitted by the grantees.

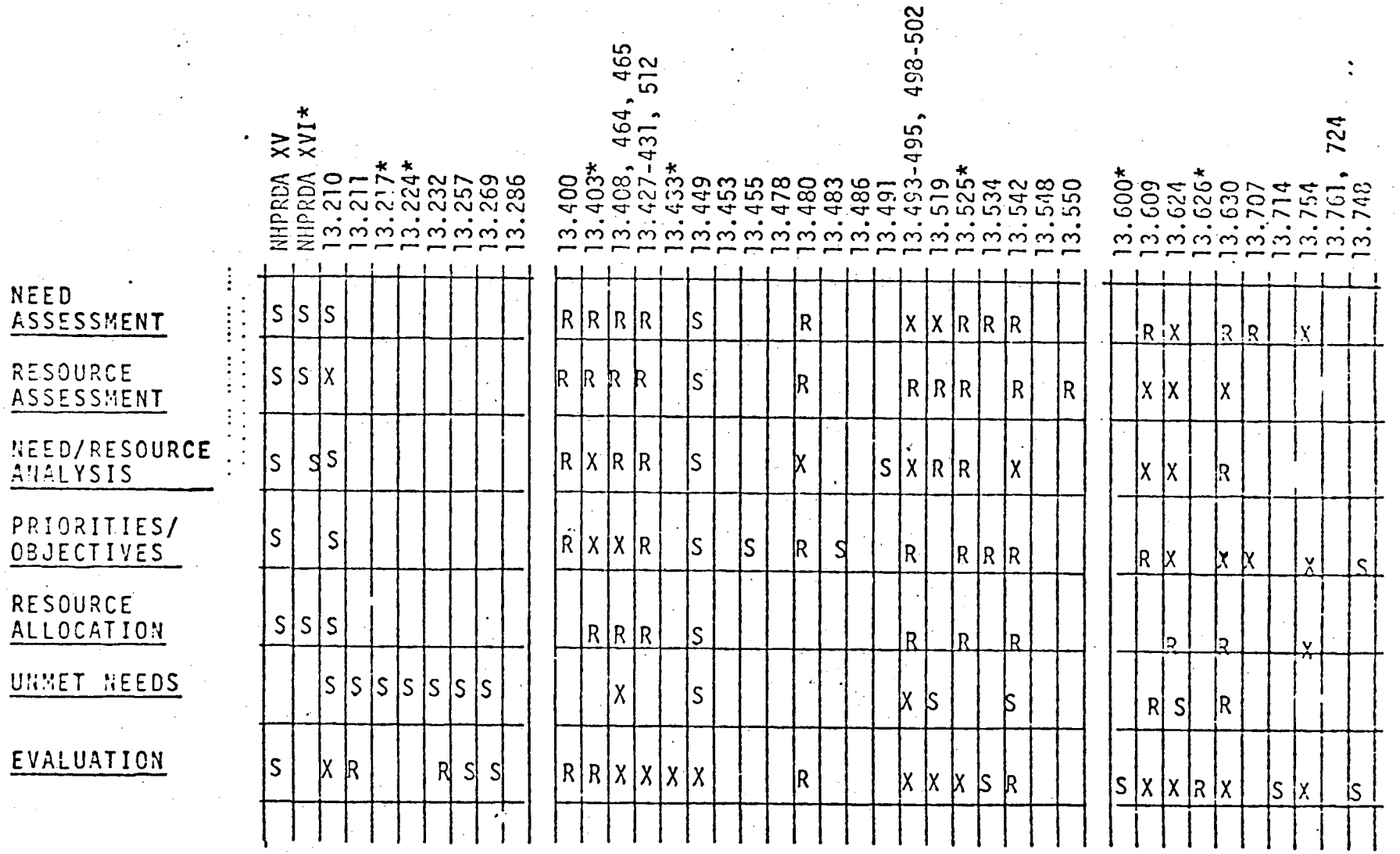
It is noteworthy that in some Federal programs a rather comprehensive set of planning specifications appears in both statute and regulation, e.g. HCDA (14.218), CETA (17.232), and Title XX Social Services (13.754), three relatively new block grant programs.

DISCUSSION

The absence of consistent Federal planning requirements between programs, even where such programs require grantee submittal of a "plan," suggests that the confusion of compliance and planning observed in HEW may exist in other Federal programs as well. The HEW effort to distinguish between planning and compliance requirements and documents might be made a more widespread Federal effort if further analysis bears out these preliminary indications.

The presence of rather extensive and indeed similar management planning specifications in the newer block grant programs in three different Departments suggests that it may be possible to design common Federal planning requirements (as distinguished from compliance requirements). These could form the basis for special adaptation to individual programs, and might lead to shared technical assistance to states or other forms of integrated services. From the grantee perspecitive, common planning requirements under several Federal programs would provide excellent incentive for integrated data collection and planning at the grantee level.

IS MANAGEMENT PLANNING REQUIRED?



* Project Grant Programs
S Required Specifically by Statute
R Required Specifically by Regulation

MANAGEMENT PLANNING REQUIREMENTS	HUD		DOI	LEAA		DOL	DOT	EPA	
	14.203	14.218	15.605 & 611	16.500	16.502	17.232	20.103	66.426	66.600
Need Assessment	S R	S R				S R			
Resource Assessment	S R	S R		S	S	S R			
Need/Resource Analysis		S R		S	S	S R			
Priorities/Objectives	S R	S R		S	S	S R		S	R
Resource Allocation	S R	S R		S	S	S R			
Unmet Needs	S R	S R		S	S	S R			
Evaluation	S R	S R		S	S	S R		R	R

S - Statutory Specification
R - Regulatory Specification

PROBLEM # 3 : Federal Eligibility and Services Specifications

Virtually all Federal grant-in-aid programs mandate planning and inter-program coordination by the state/local grantee. Both "planning" and "coordination" imply a prerogative on the part of the grantee to target resources on needs, or to apply services to the greatest needs or to needs left unmet by other services. Without such prerogatives. "planning" is wishful thinking and "coordination" is little more than meeting with other service providers.

Yet, while demanding coordination and planning of grantees, both Congress and Federal administrators often severely limit the power of state and local grantees to rationally apply resources to human needs. While Federal restrictions may not absolutely prevent state and local substantive planning and coordination, they undercut state and local management planning efforts.

Federal restrictions as to what services state/local government grantees may provide to whom tend to artificially structure, if not totally pre-determine, identification of needs. These Federal statutory and regulatory specifications are often so detailed as to make it pointless for grantees to analyze citizen needs at all. If grantees are given certain limited funds for certain limited services to certain limited groups, why should they spend much time or money finding out who needs what?

The impact of heavy Federal specification on eligibility and service falls even more heavily upon planning resources than on planning motivation. Staff resources used to verify, document, and account for state/local compliance with Federal eligibility specifications might otherwise by used to analyze citizen need and to prioritize services.

HEW PROGRAMS

The HEW study documents that HEW-administered statutes and regulations are replete with detailed eligibility and services specifications. The two charts which follow show whether such specifications are primarily regulatory or statutory in each program studied. It appears obvious that any real effort to remedy this problem must include legislative, as well as administrative change.

It is periodically fashionable to decry gaps and/or duplication in social services programs. The HEW study does neither, but rather concludes that the Federal eligibility and services specifications are so complex and detailed that it is probably impossible to be certain whether there are gaps or duplications at all.

The following charts show lists of HEW services and eligibility criteria which might have been drawn up in many different ways. However drawn, they would continue to show heavy Federal specification as to just who may receive just what services under each categorical program. The charts may be seen as something of an obstacle course for planners, as well as for the clients who seek to establish eligibility and obtain help.

OTHER PROGRAMS

Similar charts of eligibility and services specifications were not drawn up for the other programs, since the other programs studied were primarily planning, not direct service programs.

A broad study of Federal eligibility criteria across Federal Departments is now being conducted under the aegis of the Mountain Plains Federal Regional Council (Region VIII). It is called the "SPAARS" Project, for Single Purpose Application with Automatic Referral System.

The legal constraints to a single purpose application imposed by statutes and by regulations are being studied for possible change so as to make more uniform the terms, definitions, and other provisions governing a client's eligibility. Client eligibility requirements have been compiled for each program, by statute and by regulation. These eligibility requirements are then analyzed by subject classification: income, client/identification, employment, medical, veteran, education/training, state agency validation/ certification, client resources and confidentiality. Through analysis of this compilation determinations are to be made as to which terms, definitions and other provisions of client eligibility are feasible of change so that the same information obtained from a client may be used to determine the client's eligibility for more than one service need. Also, this study seeks to identify areas where administrative costs may be reduced through single agency certifications of eligibility applicable to common program administered by other agencies.

DISCUSSION

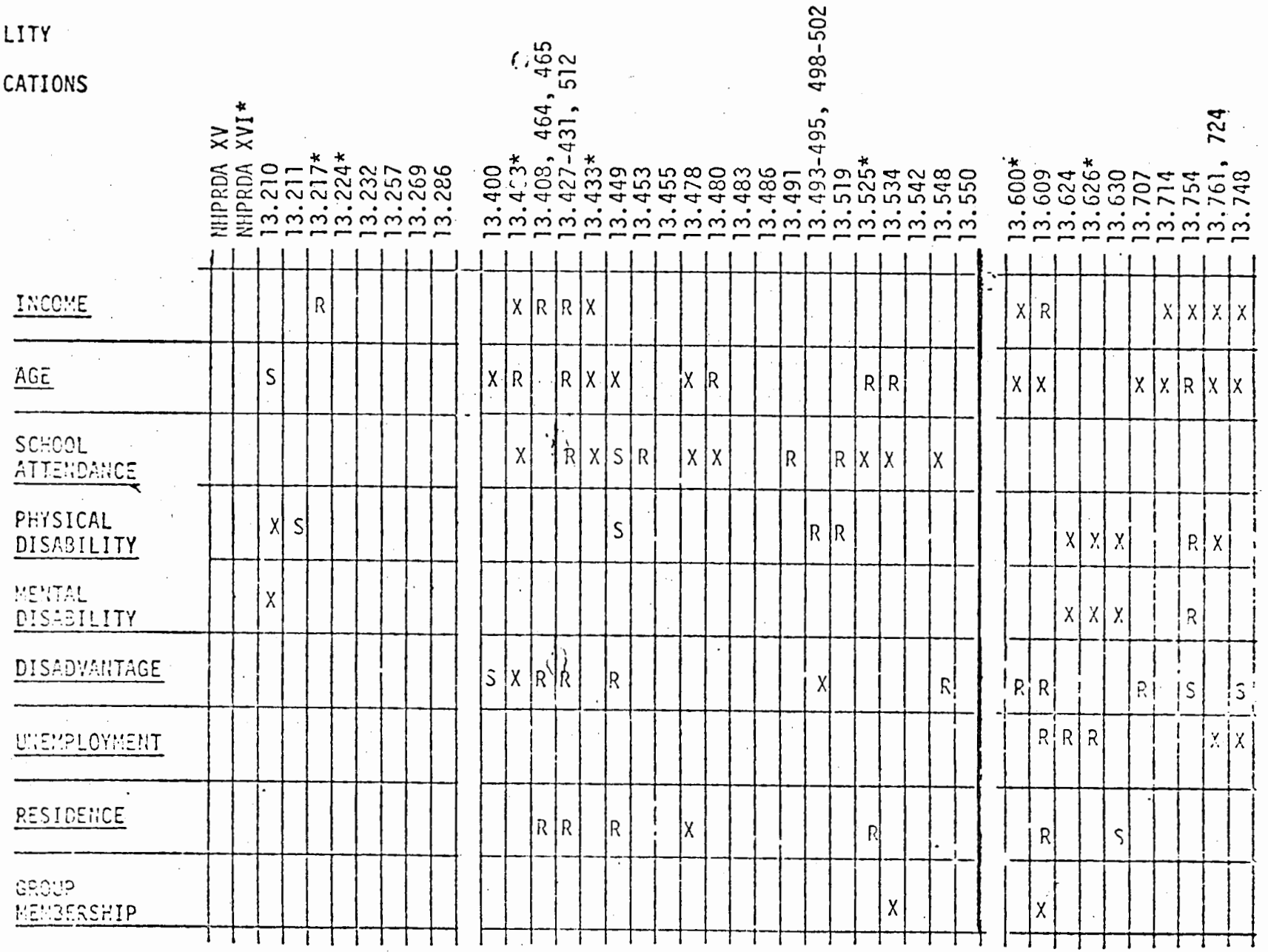
The main objective of SPAARS is to develop a simplified way for clients to apply for an array of Federal programs administered at state and local levels. Though primarily aimed at client problems with Federal specifications, the study may also be directed at state/local planning problems as well.

Specifically, the "legal constraints study" under the SPAARS effort could be used to identify Federal statutory and regulatory specifications which could be simplified to allow greater state/local flexibility to apply resources to the greatest needs, as appropriate to individual localities.

FEDERAL

ELIGIBILITY

SPECIFICATIONS

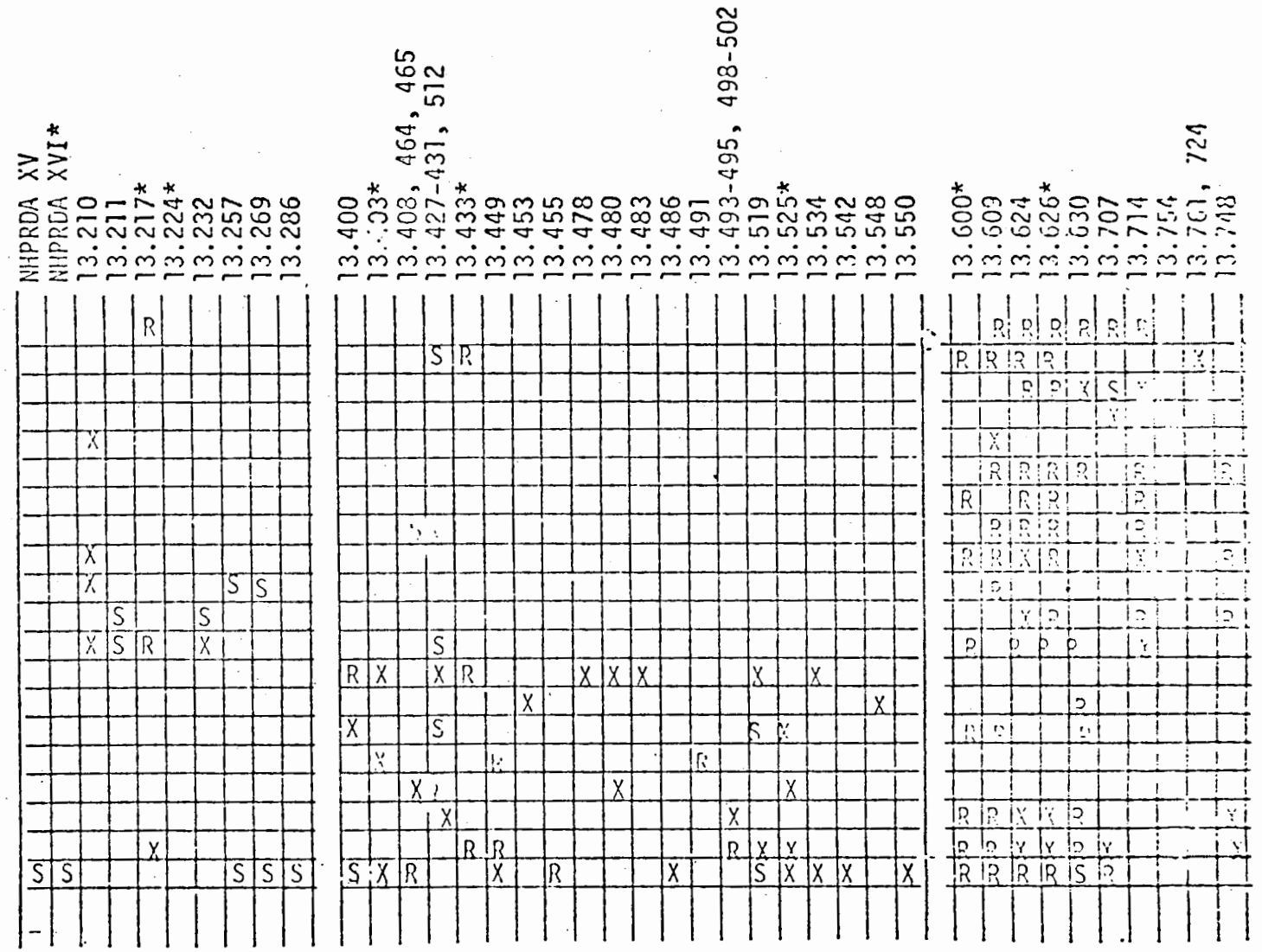


* PROJECT GRANT PROGRAMS

S SUBSTANTIALLY CIRCUMSCRIBED BY STATUTE

R SUBSTANTIALLY CIRCUMSCRIBED BY REGULATION

SERVICES SPECIFIED BY STATUTE/ REGULATION



* PROJECT GRANT PROGRAM
S REQUIRED BY STATUTE
R REQUIRED BY REGULATION
X REQUIRED BY STATUTE & REGULATION

PROBLEM # 4: ORGANIZATIONAL REQUIREMENTS

In presenting his FY 1977 Budget Message, President Ford referred to the complex array of Federal, state and local organizations and agencies engaged in administering human resources programs.

It would seem that the proliferation of Federal, state, and local agencies is partly a function of the numbers of categorical programs and the special interest groups they serve, and partly a result of the "add-a-program" approach which has characterized human services growth in the recent past. What is perhaps less well known is that Federal statutes and regulations sometimes go to considerable length to assure that individual programs will operate with minimal concern about other similar programs. Program autonomy is supported by legislators as an "accountability"measure and by program operators as an "independence" measure.

State and local governments react strongly against Federal provisions which dictate organizational structure and staffing patterns on an ad hoc, program by program basis. Such Federal provisions frequently take the form of "single state agency" and "single organizational unit" rules, although many forms of organization and staffing rules are found in Federal statutes and regulations.

HEW PROGRAMS

> *"At least since 1917, statutes administered by this Department and its predecessor agencies authorizing grants to States have required that the States, in order to receive the grants, establish or designate a particular State agency, or, in some cases, any one State agency, that would be the only agency for administering the program within the State. Both types of requirements have commonly gone under the name of "single state agency" requirements, and HEW has viewed both as waivalbe under Section 204 of the Intergovernmental Cooperation Act of 1968.*
>
> *There are many statutory requirements for organizational structures in HEW legislation which are not single state agencies and therefore cannot be waived under the Intergovernmental Cooperation Act. The single organization unit is employed as a generic term for these. The requirement for single organization units should be reviewed as Acts come up for renewal or in amending Acts containing such a requirement which have no expiration date. The requirement should be eliminated and excluded from new legislation unless there is a compelling reason for retaining it."*
>
> ("The Single State Agency Concept," a Report to the Secretary, HEW, 1973, pp. 9-10, 61.)

Since 1973, states seeking to consolidate HEW funded program agencies have found an easier way to sidestep single state agency requirements than by seeking waivers under the Intergovernmental Cooperation Act. They do so

by designating the state consolidated agency itself as the "single state agency" for each program agency included in the new organization. Single state agency requirements, however, continue to constitute a significant barrier to states wishing to divide responsibilities for a single Federal program among more than one pre-existing state agency. Interviewees expressed continuing frustration at the difficulty of obtaining a waiver under the Intergovernmental Cooperation Act of 1968.

Single organizational units, moreover, still present a significant barrier to the consolidation of administrative functions--including the planning functions--across the individual HEW programs at the state level. Single organization unit requirements demand the creation of agencies which are devoted exclusively to administering one program, and that personnel paid under that Federal grant work exclusively on that program. Some go even further and demand that any planning done for that program be done only by the same agency which exclusively adminsters the Federal funds under that program.

The practical result is that these Federal funds may not be used even in part to support a more generic planning effort. It is therefore difficult to make these programs part of a cross-program planning effort.

The HEW chart at the end of this section shows which programs contain such organizational and structural restrictions by statute and regulation. Single organization unit requirements are statutorily imposed in three programs. In terms of both statutory and regulatory restrictions, manpower planning is particularly adversely affected by these requirements, since 10 manpower programs are involved.

OTHER PROGRAMS

As the following charts show, single state agency and single organizational unit requirements appear to be rather common in both HEW and non-HEW programs. As in the HEW programs, such requirements often, but not always, originate in the statute.

No analysis was attempted as to whether such requirements present the same difficulties to state/local grantees in non-HEW programs as the HEW discussions revealed.

DISCUSSION

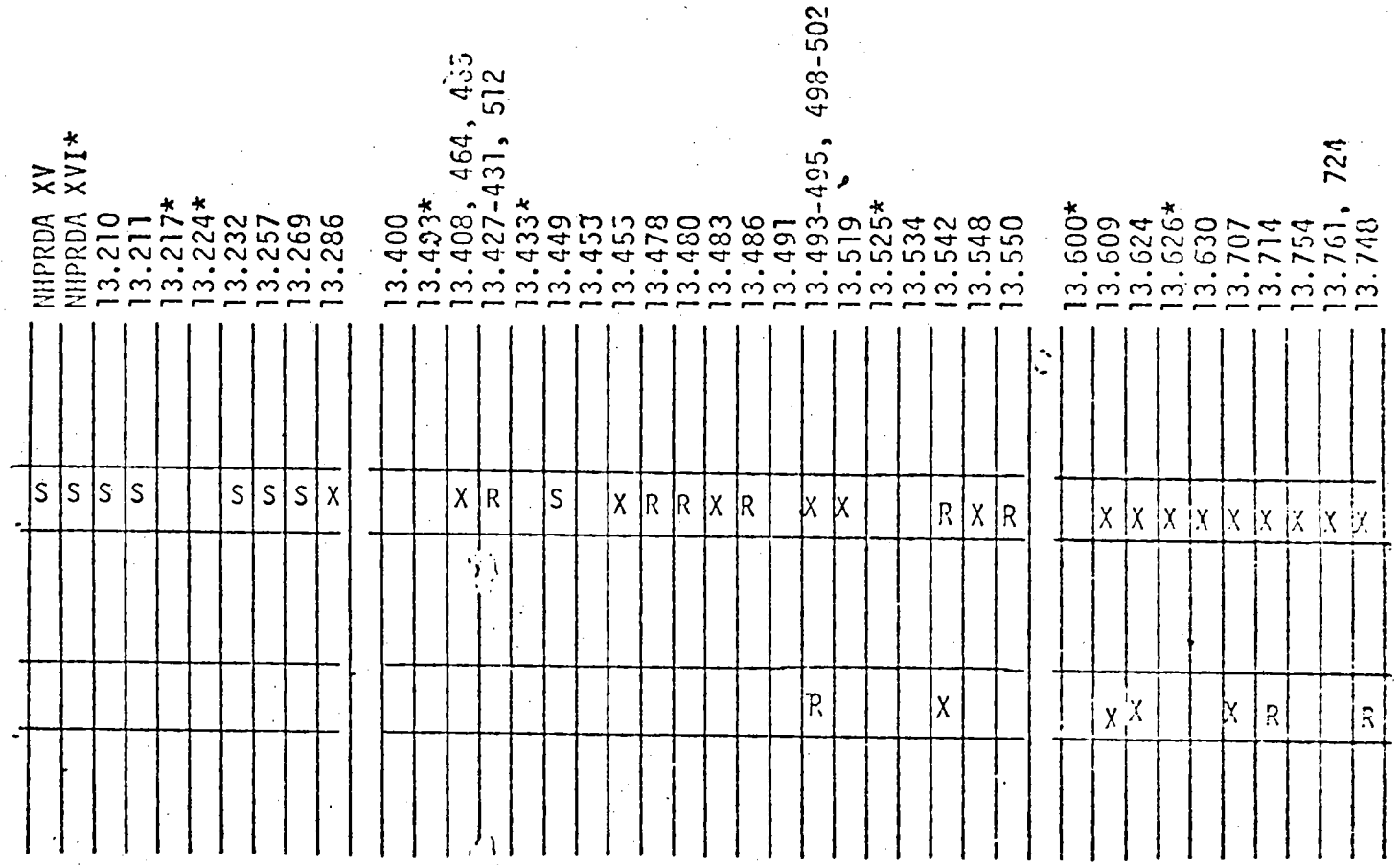
State and local grantees of HEW programs have posed the question as to whether the appropriate Federal role includes restrictions on organization and staffing at the state and local government level. If so, and if Federal accountability demands such Federal dictates, why not in all programs? Why in only some?

It would appear that the same question may be applicable to all human resources programs. Federal inconsistency in the application of such requirements between programs indicates that there is no common Federal policy on this issue.

If further analysis shows that Federal organization and staffing rules are troublesome for state and local government grantees, then this can become a concrete and identifiable issue in the area of intergovernmental debate.

ORGANIZATIONAL

REQUIREMENTS



* PROJECT GRANT PROGRAMS
S- REQUIRED BY STATUTE
R- REQUIRED BY REGULATION
X- REQUIRED BY STATUTE & REGULATION

ORGANIZATIONAL REQUIREMENTS	HUD		DOI	LEAA		DOL	DOT	EPA	
	14.203	14.218	15.605 & 611	16.500	16.502	17.232	20.103	66.426	66.600
The applicant must designate a Single State Agency or Sole State Agency.			S	S	S				S R
The applicant must designate a Single Organizational Unit, or must otherwise have a unit whose only responsibility is the administration of this program.			S	S	S	S R		S	
The applicant must comply with certain requirements (other than or in addition to the above) relating to the organization, structure or personnel configurations of the administering agency or agencies.	S R	R				S R			
State or local planning in this program must be done by a specified agency or unit: (an example would be a requirement that planning must be done by the Single State Agency).				S	S	S R		S	

PROBLEM # 5: GEOGRAPHIC DISTRICTING REQUIREMENTS

Program consolidation proponents in recent years have developed sets of overlay celluloid maps which, one by one, reveal the different sub-state districts developed for the planning or administration of individual services programs. The final composite picture is typically one in which the state map resembles a pile of spaghetti.

The proliferation of non-contiguous districts for planning or administration of state programs is obviously a barrier to cross-program planning, particularly in terms of data sharing, comparison of citizen needs and assessment of available resources outside of individual programs. It was because of this obvious difficulty that this study analyzed sub-state districting requirements, or geographical specifications in Federal statutes and regulations.

HEW PROGRAMS

As the following chart shows, the HEW statutes and regulations do indeed specify the identification and use of sub-state geographical planning and/or delivery areas for many programs. A closer look at the nature of these Federal specifications, however, shows that they are not nearly as restrictive as some state/local officials apparently presumed. Typically, the Federal requirements specify only that the grantee shall identify and/or use some sub-state districts--as determined by the grantee.

There are some exceptions to this general finding. The Educationally Deprived Children and SAFA programs specify that local school districts shall be the planning and delivery area for the programs. A few programs require that states designate urban and rural areas, but do not otherwise restrict such designations. The HEW chart shows the nature of such specifications in the statutes and regulations studied.

The major exceptions to this pattern in HEW are the National Health Planning and Resources Development Act of 1974, which specifies strict population criteria for the designation of Health Services Areas, affecting all health planning, and the Older Americans Act, which delineates factors to be used in establishing Area Agencies on Aging.

OTHER PROGRAMS

Four of the ten non-HEW programs studied show Federal requirements for sub-state districting. Closer analysis shows that the statutes and regulations in those programs not only require districts, but specify criteria against which they will be set up. Particularly problematic to state/local officials are the differences in the way various Federal programs define districts, such as "urban" or "metropolitan" areas.

DISCUSSION

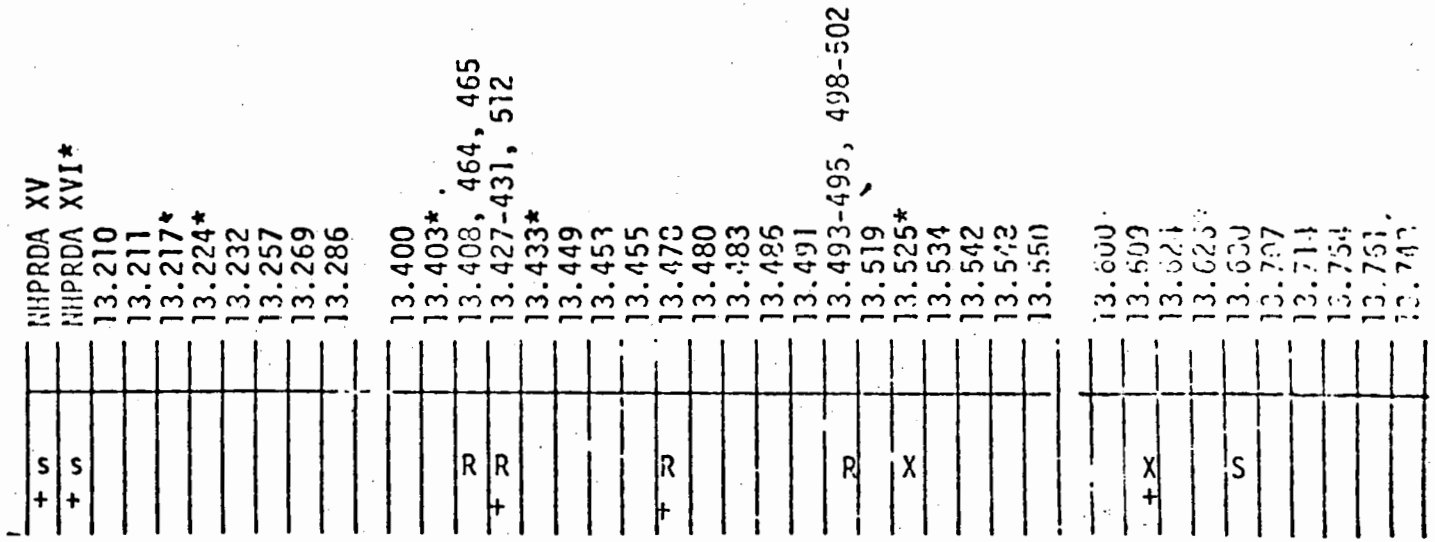
It is not the purpose of this paper to repeat the excellent studies of sub-state regionalism and other related analyses which have suggested ways to relieve the jungle of jurisdictional boundaries that exists in some states (e.g., Advisory Commission on Intergovernmental Relations, Substate Regionalism and the Federal System, 4 vols., 1973-74).

Rather, this paper suggests a more limited listing of the Federal statutes and regulations which create disparate sub-state regions, and a brief study re-confirming the hindrance which these rules pose to rational human resource planning. This data might be useful as a basis for seeking a statutory and regulatory moratorium on additional Federally imposed program specific districting. This would constitute one step in favor of more rational sub-state regionalism.

It should also be noted that Section 3075, the Intergovernmental Coordination Act of 1976, would provide added emphasis to area planning, and added flexibility for state/local government in designating area wide planning agencies.

GEOGRAPHIC DISTRICTING REQUIREMENTS

SUB-STATE DISTRICTING



* PROJECT GRANT PROGRAMS
S REQUIRED BY STATUTE
R REQUIRED BY REGULATION
X REQUIRED BY STATUTE & REGULATION
\+ DETAILED SPECIFICATIONS

GEOGRAPHIC DISTRICTING REQUIREMENTS	HUD		DOI	LEAA		DOL	DOT	EPA	
	14.203	14.218	15.605 & 611	16.500	16.502	17.232	20.103	66.426	66.600
Sub-State geographic areas must be designated under this program for planning or delivery of services.	S R					S R		S	S

PROBLEM # 6: ADVISORY GROUP REQUIREMENTS

The Federal government is deeply involved in telling state and local government grantees who shall advise them in planning for human services. The Federal specifications are apparently aimed at forcing grantees to pick advisors who have some knowledge of, or are affected by, the programs. State and local program managers feel that this may put strings on the evaluative judgments which are part of the planning for the programs. Additionally, in some areas (particularly rural areas) membership requirements may cause some special groups to duplicate their participation on many advisory groups.

The Federal government is also involved in determining the authority and responsibilities of advisory groups. There are some cases where Federal requirements concerning the authority of advisory councils directly conflict with state and local legislative authorities, thereby precluding some governmental units from being grantees.

Perhaps the most important point cited by HEW interviewees is that Federal advisory group requirements tend to focus on a single approach to citizen influence. As state and local governments experiment with other methods of including citizens in the planning-decision making process, (e.g., publication of plans, public hearings, task forces, public comment mechanisms such as "hot lines") they are finding

- a "mix" of approaches is often necessary and desirable

- the approaches which appear to result in the most effective citizen involvement vary greatly in different situations.

HEW PROGRAMS

In the 54 HEW programs studied, some 14 state advisory committees are required, plus local advisory committees in at least 8 of the programs. Approximately half of these requirements are based in statutes.

The Federal regulations on advisory committees are incredibly detailed as to the make-up, and sometimes the functions, of the groups. Most specify that the groups are to be made up of various combinations of consumers of the particular program, professionals providing a given service, and other citizens with various characteristics such as residence in a given area, income level, etc. In 7 programs, regulations and/or statutes specify that program operators must form part of the advisory groups.

The following chart shows which programs have these requirements in statute and/or regulation. Most of the advisory groups are charged with providing input to, helping to develop, or reviewing and commenting upon the plans and applications prepared for those programs. A few have more extensive administrative responsibilities. For the most part, these groups advise the state or local agencies administering the programs, not elected officials or the Federal government directly. The study did not attempt to evaluate in-depth the content or effects of the advisory activities.

OTHER PROGRAMS

As the final chart in this section shows, four of the non-HEW programs studied require state and/or local advisory groups by statute and/or regulation. Whereas the HEW study was able to indicate heavy reliance on the advisory group approach as opposed to other forms of citizen input mechanisms, the extension of this issue to other programs does not allow such a conclusion. It does little more than to verify that advisory group specifications are not just an HEW phenomenon.

DISCUSSION

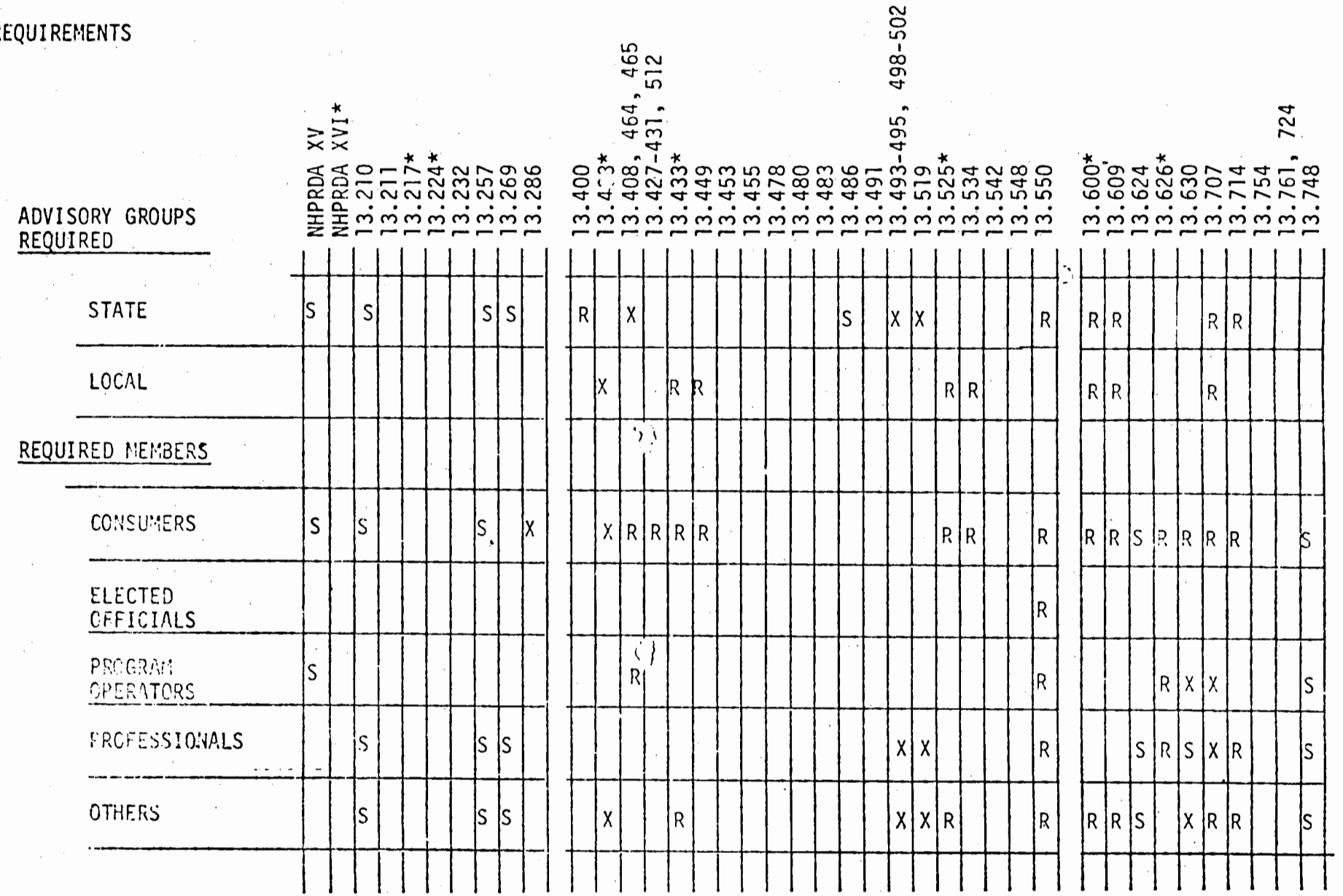
It is anticipated that further analysis would show advisory groups to be a rather common focus of Federal statutory and regulatory specification. If so, an analysis of the relative effectiveness of such groups in assuring citizen influence upon program decisions might be fruitfully conducted across a number of departments.

Such an analysis might reveal whether Federal specification of certain citizen-input mechanisms is successful, under what circumstances, and how citizen influence may be more generally and effectively applied to all Federally-funded human resources programs.

nEW

ADVISORY GROUP

REQUIREMENTS



* PROJECT GRANT PROGRAMS
S REQUIRED BY STATUTE
R REQUIRED BY REGULATION
X REQUIRED BY STATUTE & REGULATION

ADVISORY GROUP REQUIREMENTS	HUD		DOI	LEAA		DOL	DOT	EPA	
	14.203	14.218	15.605 & 611	16.500	16.502	17.232	20.103	66.426	66.600
Advisory Groups Required									
State	R			S	S	S R			
Local				S	S	S R			

S - Statutory Specification
R - Regulatory Specification

PROBLEM #7: FEDERAL FUNDING RULES

It is unclear to what extent Federal allocation formulae, financial participation formulae, and maintenance of effort requirements determine how much money, in the aggregate, is spent for human services. These requirements determine whether those expenditures will come from Federal revenues or state/local government revenues. To the man in the street, these Federal specifications govern whether his Federal taxes or his other taxes will pay for the services provided.

Federal allocation formulae determine which portion of a Federal appropriation will go to each state or local jurisdiction. The formulae contain many criteria, some of which require census-type counts of citizens who fall into certain categories. For example, Indian Education Grants to Local Education Agencies depend upon the number of Indian children in a given school district, compared with the number of non-Indian children, and with the number of children in school nationwide.

Federal financial participation (FFP) formulae--better known as state/local matching requirements--determine what portion of each dollar spent on a service program must be "put up" by the state or local jurisdiction so as to "draw down" the rest of the dollar from the Federal government. If the FFP is 75%, then the state/local grantee must provide 25% of the funds required to provide the services of that program to its citizens.

Maintenance of effort requirements are any specifications designed by the Federal government to ensure that Federal funds will not displace the state or local funds already being spent in providing a given service as of a certain date, usually before the Federal funds became available. Sometimes a grantee may not provide less than he did during the year just previous to the current one; the state or local government must "maintain its effort" in the program.

HEW PROGRAMS

The first chart in this section shows whether these three types of requirements are found in statutes, regulations, or both, for each of the programs studied. The second chart shows the FFP percentages. Where more than one formula applies in one program, depending on various circumstances, each of the possible FFP rates is shown. As this chart shows, these requirements are many and varied within the HEW programs studied. They are heavily grounded in statute, although there are some programs in which one or more of the requirements appear to be based on regulation alone.

The second chart presents a quick picture of the array of Federal financial participation rates in each of the HEW programs. It show that some programs offer as many as four different matching rates, depending on circumstances within the program site.

This study asked state and local officials about the influence of the FFP formulae on state and local government priority setting. Of the 49 who discussed this question, 25 felt that the FFP has a "great influence" on such priorities, 17 felt that the FFP influenced state and local priorities "somewhat," and 7 saw no influence. Not all of those who believe that the FFP influences priorities see this as undesirable; some point out that the Federal matching funds are useful in encouraging state legislatures to provide the matching funds.

OTHER PROGRAMS

The third chart in this section shows that the array of Federal matching rates is probably as variable as in HEW programs. Respondents were not asked to identify whether such rates are statutorily or regulatorily set, but it is a safe assumption that, as in HEW programs, statutes determine most of these rates.

The third chart also shows that half of the programs studied contain, by statute and sometimes regulation, requirements that the grantee maintain fiscal effort with non-Federal money, or provisions against displacement of state/local funds with Federal funds.

The Great Lakes Federal Regional Council (Region V, Chicago) has done an extensive analysis of allocation formulae. The findings of that study which bear repeating here are: "(a) that the cumulative effect of these formulae on any one state is unpredictable, (b) that the individual program formulae often bear a questionable relationship to the purpose of the program or the clientele to be served, and (c) that further study of this relationship is warranted and would probably suggest a need for statutory change in many programs."
(Region V FRC Resource Allocation Task Force, "An Introduction to Formula Grants," July 1975.)

In view of the extensive Region V FRC effort, no analysis was made here about allocation rates. The Region V FRC report covers 40 programs in all. These include 25 HEW programs, 20 of which are also covered in the Region X HEW Planning Study, plus 15 other Federal programs, 5 of which are common to this analysis as well:

DOI	15.605 and 611
LEAA	16.500 and 502
DOL	17.232

DISCUSSION

The multitude of Federal matching rates is rather easily understood in terms of its historic origin in Congress. Variable matching rates enable

Congress to recognize a need without assuming the full burden for serving it. FFP formulae are, in fact, a sort of "proportionate maintenance of effort" requirement, i.e., so long as Federal funds are used to meet this need, the state or local government must carry its "share" of the load. FFP formulae also appear to indicate a set of Congressional priorities; a program funded 100% with Federal funds would appear to be more important to the Congress than one funded at 50%. In fact, however, given the piecemeal way in which the programs have arisen, it is doubtful that the formulae should be understood to represent Federal priorities; they may better represent available Federal funds at the time of the authorization, or the make-up of the authorizing committee and the current expenditures of their own states in a given type of service program.

Whatever the reasons for the origin of the FFP formulae, the end result is a grab-bag of matching rates, some more appealing to state and local governments than others. At the very least the "system" makes for unnecessary complication and budget paperwork; at worst, it skews state and local priority-setting away from an objective response to needs and towards a purely fiscal response to the most advantageous Federal matching rates.

Fixed dollar maintenance of effort (M of E) requirements indicate that either (a) the Federal Government does not expect the problem to go away, or (b) it wants to pull Federal money out first if the problem does start to go away. Fixed-dollar M of E requirements are not necessarily less advantageous to state and local government than proportionate M of E requirements (FFP); that depends on where the fixed dollar line is pegged and what happens to the total cost of the program over the years. Fixed-dollar M of E requirements, however, constitute a greater disincentive for the grantee to engage in creative action to remove this problem or to administer the service more efficiently. Under fixed-dollar M of E, the grantee saves nothing until the cost of the program falls below the M of E level. Fixed-dollar M of E requirements also imply a risk for the grantee. If the local appropriation drops below the M of E line, all the Federal funds are in jeopardy. Most significantly, of course, fixed-dollar M of E requirements prevent state and local governments from shifting state and local dollars to better address the variable needs within the citizenry.

While fixed-dollar M of E requirements may be useful for limiting Federal expenditures, they do so at the direct expense of state/local flexibility. They directly limit state/local ability to adjust resources to needs and penalize states which provided funds to resolve those problems before a Federal program was instituted.

In sum, all three types of federal funding rules (FFP, M of E, and Allocations) represent micro-mechanisms for applying incentives and strictures to the

spending of state/local dollars along with the federal dollars offered by Congress. These mechanisms are "rationalized" on a program-by-program ad hoc basis, but the CUMULATIVE effect of such mechanisms on state and local governments is never analyzed nor rationalized. Were this done, it might be that a more effective set of Federal incentives to state/local effort could be devised. At the very least, a simpler and more efficient process for mixing public dollars could probably be designed. A less efficient and more complex system than the present one would be hard to conceive.

HEW

FEDERAL FUNDING RULES

	NHPRDA XV	NHPRDA XVI*	13.210	13.211	13.217*	13.224*	13.232	13.257	13.269	13.286	13.400	13.403*	13.408, 464, 465	13.427-431, 512	13.433*	13.449	13.453	13.455	13.478	13.480	13.483	13.486	13.491	13.493-495, 498-502	13.519	13.525*	13.534	13.542	13.548	13.550	13.600*	13.609	13.624	13.626*	13.630	13.707	13.714	13.751	13.761, 724	13.748
FIXED DOLLAR MAINTENANCE OF EFFORT	S		X						S		X	S	X	X	R					X		S	X	X	X	R	X	S	R			R			R		R	R	R		
DISTRIBUTION FORMULAE	S	S	X	S			S	X	X		S	S	S	X		S	S	S	S	S	S	S	S	S	S	S	X	S		R	S	X	X		X	X	S	X		S	
FEDERAL FINANCIAL PARTICIPATION	S	S		X	X		X	S	S	R	R	R	X	R	X	S	S	S	S	S	S			R	R	S	R		R	R	S	X	X	X	X	X	S	S	X	X	X

* PROJECT GRANT PROGRAMS
S REQUIRED BY STATUTE
R REQUIRED BY REGULATION
X REQUIRED BY STATUTE & REGULATION

FEDERAL FINANCIAL

PARTICIPATION FORMULAE

HEALTH

NHPRDA XV	c. 75% (varies somewhat)
NHPRDA XVI *	66-75-90-100%
13.210	Less than 100%
13.211	Less than 100%
13.217 *	Varies
13.224*	Less than 100%
13.232	100%
13.257	100%
13.269	50% Maximum
13.286	90%

EDUCATION

13.400	100%
13.403 *	50%
13.408,464,465	Varies
13.427-431,512	75-80-84-86%
13.433*	100%
13.449	100%
13.453	100%-80%-70%
13.455	100%
13.478	100%
13.480	100%
13.483	100%
13.486	100%
13.491	50-100%
13.493-495, 498-502	85%
13.519	100%
13.525 *	50%
13.534	100%
13.542	100%
13.548	100%
13.550	80%

INCOME MT. AND SERVICES

13.600 *	75-90%
13.609	80% or 10%
13.624	90-100%
13.626 *	100%
13.630	75-90%
13.707	Varies
13.714	50-83%
13.754	75-90%
13.761, 724	Varies
13.748	90%

FEDERAL FUNDING RULES	HUD		DOI	LEAA		DOL	DOT	EPA	
	14.203	14.218	15.605 & 611	16.500	16.502	17.232	20.103	66.426	66.600
Federal Financial Participation Rates (%)	66	100	75	90	90 50	100	67	100	75 95
Maintenance of Effort or Similar Requirement in Statutes, Regulations		S R		S	S	S R			

Problem 8: Locus of Federal Responsibilities

Since the advent of the Catalog of Federal Domestic Assistance, the state/local problem of locating Federal fund sources has been markedly reduced. Grantees can determine from the Catalog what programs they may potentially apply for and where to begin applying. Receiving and maintaining a Federal grant, however, implies more than simply applying, and there is little information in the Catalog as to how grants are processed and maintained. At least nine basic activities comprise the Federal role in both formula and project grant programs:

1. Receiving the plan or application.
2. Reviewing plan or application and recommending grant action.
3. Approving the grant, or
4. Disapproving the grant.
5. Holding the official plan or application of record.
6. Issuing the grant award.
7. Monitoring of grantee program performance.
8. Grants management, compliance & fiscal monitoring of grantee.
9. Providing technical assistance to grantee.

Grantees, particularly inexperienced ones, often have occasion for confusion as to which Federal office is responsible for which of the above functions.

HEW PROGRAMS

As the following HEW chart shows, the functions identified above are divided rather inconsistently between the central and regional offices of HEW, even within individual agencies, e.g., the Office of Education.

This inconsistent locating of Federal responsibilities poses an obvious problem should a state or local government hope to present to HEW a consolidated plan or application covering more than one program--namely, who in HEW does what with respect to such a plan or application?

Aside from the special problems of consolidated planning or application submittal, the inconsistent locus of responsibility within HEW works against any attempt of a state of local government planner, budget officer, program administrator, or elected official to track Federal actions across a number of programs operating in his jurisdiction. There is no simple way for him to find out where the Federal responsibilities are lodged. No charts such as the one presented here are publicly available, nor is there any assurance that this one will long remain current.

OTHER PROGRAMS

As the final chart in this section shows, other Federal programs appear to

be more heavily regionalized, in general, than many HEW programs. There may well be less confusion among state/local grantees of these programs than is the case in HEW programs.

DISCUSSION

If further analysis indicates that HEW is a unique locus of this problem, the finding may be useful in addressing a recent Congressional trend to specify the locus of responsibility in programs such as Vocational Rehabilitation, Older Americans, and Education programs.

LOCUS OF FEDERAL RESPONSIBILITIES	NHPRDA XV	NHPRDA XVI*	13.210	13.211	13.217*	13.224*	13.232	13.257	13.269	13.286	13.400	13.403*	13.408, 464, 465	13.427-431, 512	13.433*	13.449	13.453	13.455	13.478	13.480	13.483	13.486	13.491	13.493-495, 498-5	13.519	13.525*	13.534	13.542	13.548	13.550	13.600*	13.609	13.624	13.626*	13.630	13.707	13.714	13.754	13.761, 724	13.748
Receives P/A					X	X		X		X		X		X										X		X					X	X	X	X	X	X	X	X	X	X
Reviews P/A					X	X	X	X	X	X		X	X	X				X		X				X		X					X	X	X	X	X	X	X	X	X	X
Approves			X		X	X	X	X		X																					X			X						X
Disapproves			X		X	X		X		X																								X						
Holds Official Document			X	1	X	X	1	X		X		X		X										X		X					X	X	X	X	X	X	X	X	X	X
Issues Grant			X	X	X	X	X	X		X		X		X										X		X					X			X					X	X
Financial Management			X	X	X	X	X	X		X		X		X												X	X				X			X						X
Grants Management (Compliance)			X	X	X	X	X	X		X		X		X										X		X					X	X	X	X	X	X	X	X	X	X
Program Monitoring (Objectives)			X	X	X	X	X	X		X		X		X										X		X					X	X	X	X	X	X	X	X	X	X
Technical Assistance			X	X	X	X	X	X		X		X		X										X		X					X	X	X	X	X	X	X	X	X	X

* PROJECT GRANT PROGRAMS
1 PLAN OR APPLICATION HELD IN STATE OFFICE
X REGIONAL OFFICE RESPONSIBILITY

LOCUS OF FEDERAL RESPONSIBILITIES	HUD		DOI	LEAA		DOL	DOT	EPA	
	14.203	14.218	15.605 & 611	16.500	16.502	17.232	20.103	66.426	66.600
Receives plan/application	X	X	X	X	X	X	X	X	X
Reviews, recommends action	X	X	X	X	X	X	X	X	X
Final approval	X	X	X	X	X	X	X		X
Final disapproval	X		X	X	X	X	X		X
Holds the Document of Record	X	X		X	X	X	X		X
Issues grant award	X	X	X	X	X	X	X	X	X
Program monitoring responsibility	X	X	X	X	X	X	X	X	X
Grants management responsibility	X	X	X	X	X	X	X	X	X
Provides technical assistance	X	X	X	X	X	X	X	X	X

X - Regional or Area Office Responsibility

(No X - National or Central Office Responsibility

PROBLEM # 9: DUE DATES

Some State and local governments commit substantial time and resources to keeping informed of available Federal assistance; others are unwilling or unable to make such an effort. Further, the system's complexity has encouraged and almost required State and local governments to engage increasingly in grantsmanship.

The Federal Government has no single source of reliable and complete information on the type and availability of Federal assistance programs for State and local governments. Because of the proliferation of such programs, State and local governments have devoted considerable time and effort to identifying, keeping informed of, and availing themselves of Federal assistance. Despite their efforts, many State and local officials do not learn of available Federal assistance or learn of it too late to apply. (General Accounting Office, "Fundamental Changes Are Needed in Federal Assistance to State and Local Governments," August, 1975, pp. 19,22.)

A major part of the state/local difficulty of keeping up with Federal grant programs is the task of identifying the dates each year on which plans and applications are due to the various Federal agencies. Early knowledge of the due date is obviously critical to state/local ability to produce quality plans and applications. It is also important from the perspective of the state/local manager trying to deploy staff time wisely.

The problems which the Federal system creates in formula programs differ from the problems created in project grant programs. The state formula grantees expect to submit annual documents. Their problem is being sure to learn each applicable due date in time to prepare the document required. This problem is compounded for elected officials and planning or budgeting officers who may wish to compare plans in different stages of development at any given time. For project grant applicants, including state and local governments, the problem is tracking available funds and due dates so as to make timely application.

HEW PROGRAMS

The HEW study confirms the GAO finding that state and local governments must spend considerable staff time to track Federal due dates. There is annual anxiety and confusion about due dates for plans and applications submitted to HEW and the array of submittal dates makes cross-program planning all but impossible.

This study found that in about half of the programs studied the due date for state/local submittal of annual plans or applications to HEW changes each year. The dates generally fall between January and July. Some are announced via the Federal Register; others are announced by letters to the prospective grantees, program memoranda, policy instructions, or informational bulletins. All are set by the Central Office HEW program agency with the exception of three health programs in which the regional health agencies set the date (Family Planning, Health Services Development Project Grants, and Alcohol Formula Grants), and one other program in which the states choose

between alternative dates (Title XX Social Services). The following chart shows which programs have changeable due dates and how these are announced.

OTHER PROGRAMS

It would appear that extension of the HEW analysis to other federal programs would quickly confirm the GAO findings. As the final chart in this section shows, (1) due dates vary greatly among programs, (2) most programs tend to change the due dates for plans and applications frequently, and (3) the due dates are ordinarily set by the national office, though sometimes by area or regional offices.

Perhaps most surprizing is the indication that none of these non-HEW programs announces the due date for plans and applications via the Federal Register, which is the only official and universal Federal organ for such information.

DISCUSSION

The aforementioned GAO report urges greater information-sharing activity under the FRC system as a solution to state/local grantee information problems.

A more immediate and direct solution to the more limited problem of due dates may be possible, especially since such a solution apparently would not involve changes in either statues or regulations. The primary solutions being considered by HEW are:

(1) Allowing States to pre-select their own due dates for all or groups of Federally-required formula grant plans. E.g., a state would announce that its Federally-required plans for HEW and DOL formula grants will all be completed by March 31 for the fiscal year beginning the following October 1. Once selected, that date would be binding and no more flexible than the current Federally-set date. But the state would have chosen it to allow cross-comparison of plans and to accommodate the state's own planning, budgeting, and legislative cycles.

(2) For project grant programs, where equitable competition must be assured, Federal agencies would announce on a set date in the Federal Register all the various due dates for all project/discretionary grant programs in the succeeding year. There would still be exceptions in the form of new programs legislated after the publication date, and perhaps appropriation timing problems, but these would not be as extensive as the present system of helter skelter due date announcements.

ANNOUNCING DUE DATES	NHPRDA XV	NHPRDA XVI*	13.210	13.211	13.217*	13.224*	13.232	13.257	13.269	13.286	13.400	13.403*	13.408, 464, 465	13.427-431, 512	13.433*	13.449	13.453	13.455	13.478	13.480	13.483	13.486	13.491	13.493-495, 498-502	13.519	13.525*	13.534	13.542	13.548	13.550	13.600*	13.609	13.624	13.626*	13.630	13.707	13.714	13.754	13.761, 724	13.768
MONTH PLANS/APPLICATIONS WERE DUE LAST YEAR			7		3				7			6	3	7	3	1		6		1				6	6	5	1	5	1	2		7	5		5					7
DUE DATE CHANGES ANNUALLY										X					X	X	X						X			X	X		X			X	X							X
FEDERAL REGISTER		X							X	X		X	X	X		X		X	X	X	X	X		X	X		X	X		X	X		X		X		X		X
LETTER		X	X		X	X			X																															
PROGRAM INSTRUCTION																																	X		X					
PROGRAM MEMO																X						X			X			X												
INFORMATION BULLETIN															X																									

DUE DATES	HUD		DOI	LEAA		DOL	DOT	EPA	
	14.203	14.218	15.605 & 611	16.500	16.502	17.232	20.103	66.426	66.600
Due date of plans/applications last year (Month)	4	4		5	9	6		5	4
Date changes every year	X	X		X	X	X		X	X
What Federal office determines this date Regional, National (Central)	N	R		N	N	N		N	R
Date announced in									
Federal Register									
Other	X	X		X	X	X		X	X

PROBLEM # 10: ANTICIPATING FEDERAL RESOURCES

> *"Uncertainty about funding reduces the value of planning on the part of State and local governments and makes such planning more difficult. Such uncertainty makes State and local governments react to Federal assistance as it becomes available and discourages planning for the integration of Federal programs into their functions. This impact on the planning process also makes program implementation more difficult and less efficient and effective."*
>
> (GAO Report, op. cit., p. 26.)

The single greatest barrier to improved planning, according to state and local officials interviewed in the HEW study, is the timing problem. Grantees cannot accurately anticipate Federal resources early enough to plan the coming year's budget adequately. Reliance on the previous year's funding fugure, adjusted by hearsay and guesswork is standard operating procedure for grantees.

The following calendar shows two fiscal year: Year 1 is the planning year, Year 2 is the operating year.

	July - Beginning of FY
	Oct. - State Agencies Prepare Budgets
Year 1	Jan. - Legislatures Convene/President's Budget Announced
	Feb. - Federal Projections
	June
	July - Beginning (old) FY
	Oct. - Beginning (new) FY/Appropriations
Year 2	Jan.)
	Feb.) Old appropriations, allocations
	June)

In about October of Year 1 state agencies must prepare their budgets for Year 2's operations. They do so to be ready for their legislatures which convene in January of Year 1. But usually the legislatures have already convened before the President presents his budget message in January. Then it isn't until sometime during the operational year, Year 2, that the state agencies and legislatures know what the actual Federal appropriation is and their state share will be for the programs they are operating. In short, state agencies and state legislatures must both engage in considerable guesswork to anticipate Federal funds.

The new Federal fiscal year won't address this problem directly. It may produce appropriations and thereby allow state allocations early in Year2, but state agencies will still do their basic budgeting back in September or October of Year 1, to prepare for the January meeting of the state legislatures, and the President still won't announce the Federal budget request until after those legislatures convene.

HEW PROGRAMS

State and local officials, in discussion with HEW, spoke in considerable detail about when their program budget requests must be submitted to their state/local planning or budgeting offices each year, when they receive dollar projections and final grant figures from HEW, and when they would like to receive solid Federal figures for their own planning and budgeting purposes.

The responses show that state/local agency budget requests are usually made in September or October (9 or 10 months before the beginning of the applicable Federal fiscal year), so that state/local budgets can be prepared before the beginning of the legislative sessions in January. They ordinarily receive their first Federal projections between February and May, 2 to 5 months before the fiscal year) and their actual Federal allocations after the beginning of the applicable fiscal year. Even after the Congressional appropriations,some state allocations are delayed for months while HEW factors the latest data into its complex allocation formulae.

Most interviewees felt that it is not unreasonable for them to receive firm Federal dollar estimates a month or so before they submit their budget requests, i.e., in July or August (one year in advance of the July fiscal year, 15 months in advance of the new Federal fiscal year beginning in October.) The Congressional Budget Act and the new Federal fiscal year are not expected to solve this problem. The President's budget announcement will still be in January, and it serves as the primary basis for Federal projections. The state legislatures will continue to convene in January, and this establishes the state budgeting timetable. Thus the question remains: How can HEW get good figures to state/local grantees 12-15 months before the fiscal year begins?

OTHER PROGRAMS

General inquiries among the ten other Federal programs showed that most are unable to give Federal projections of state allocations with any certainty until at least March of Year 1 - some time after the state agencies have prepared their own budgets. Apparently, however, early appropriations in some Federal programs have enabled them to prepare actual state allocations almost as early as their Federal projections, thereby providing grantees with firm figures in advance of, or at least early in, the operational year.

Such a situation, while clearly preferable to that observed in most HEW programs, still does not approach the ideal of state and local government officials: knowledge of Federal resources before they prepare their own budgets.

DISCUSSION

Earlier Federal appropriations and speedier Federal allocations always represent improvements from the perspective of state/local planners. However, there are only two possible solutions which approach the ideal: (1) forward funding or (2) multi-year appropriations.

Forward funding has been employed in some Education programs--to the great satisfaction of state/local education administrators. An expansion of the programs covered by forward funding is included in the President's current Education Block Grant proposal.

It would appear however, that forward funding is not an unalloyed solution:

> *"Our recommendation about forward funding and authorizations and appropriations for longer than 1 fiscal year was broadly endorsed; most respondents agreed its full adoption would significantly reduce funding uncertainties for potential grantees. However, OMB and some other respondents had serious reservations about forward funding; they noted it would restrict Federal fiscal policy and overall budget flexibility by increasing the number and size of relatively uncontrollable programs in the Federal budget."*
>
> (GAO Report, op. cit., p. 51.)

Whatever the full scope of national considerations which should be included in this discussion, this preliminary analysis sheds light on one point: from the perspective of state/local government planning, timing incompatibility is possibly the most serious of all problems. At present the Federal government is in the posture of requiring state/local governments to plan, and simultaneously forcing them to attempt planning on the basis of guesswork about Federal resources. As the Federal share of resources gradually outweighs the state/local shares, this Federal position becomes less and less defensible from a planning perspective.

PART III

PART III

SUMMARY OF RECOMMENDATIONS

Each of the ten problems identified in this report appears to be common to many Federal programs. Generally, it is recommended that this study be expanded to cover a larger number of Federal programs with state or local government grantees.

Following, in brief form, are the other more specific recommendations made in this report for addressing each of the problems identified.

Problem 1: The Documentation Blizzard

Recommendation: Simplification or standardization of primary grant documents, such as Federally-required state plans and grant applications.

Problem 2: Inconsistent Federal Planning Requirements

Recommendations:

(1) Distinguish in Federal statutes and regulations between planning and compliance documentation; do not call compliance documents "plans."

(2) Design general or common Federal planning requirements for grant-in-aid programs; allow adaptation to individual programs.

(3) Increase training of federal employees and technical assistance to state/local governments on planning techniques.

Problem 3: Federal Eligibility and Services Specification

Recommendation: Build upon the legal constraints study under the SPAARS Project (Region VIII FRC) to simplify Federal statutory and regulatory specifications as to who may receive what services in client-related programs.

Problem 4: Federal Organizational Requirements

Recommendations:

(1) Analyze present utility and drawbacks of single state agencies, single organizational units, and other Federally-required organizational structures and staffing patterns for state/local grantees.

(2) Develop a standard Federal policy applicable to all programs in this respect, delineating the appropriate limits of such Federal specifications in an intergovernmental system.

Problem 5: Geographic Districting Requirements

Recommendations:

(1) List all statutes and regulations which require sub-state districting,

(2) Analyze appropriate degree of Federal specification vs. state/local choice,

(3) Identify and correct conflicting statutory and regulatory definitions of areas, such as "urban" and "metropolitan" areas.

Problem 6: Advisory Group Requirements

Recommendations:

(1) Analyze the relative effectiveness of advisory groups vs. other mechanisms for assuring citizen influence in Federally-supported programs.

(2) Identify the appropriate degree of specificity needed in Federal statutes and regulations to assure equitable citizen influence on governmental decisions and priorities.

Problem 7: Federal Funding Rules

Recommendations:

(1) Analyze the cumulative effect of matching rules, maintenance of effort requirements, and allocation formulae upon state/local governments.

(2) Develop an overall Federal policy on incentives to state/local grantees, and alternatives for simplifying these funding rules.

Problem 8: Locus of Federal Responsibility

Recommendation: Analyze pattern of regional vs. national office grants management responsibilities in Federal programs; determine whether further standardization would be advantageous to state/local grantees.

Problem 9: Due Dates

Recommendations:

(1) Allow each state to select a common plan due date applicable across Federal formula grant programs.

(2) Publish simultaneously in the Federal Register all due dates for project/discretionary grant programs.

Problem 10: Anticipating Federal Resources

Recommendation: Extend forward funding and multi-year appropriations to more grant-in-aid programs.

APPENDICES

APPENDIX I

PROGRAMS STUDIED

HEALTH

National Health Planning and Resources Development Act of 1974-Titles XV, XVI
13.210 Comprehensive Public Health Services-Formula Grants
13.211 Crippled Children's Services
13.217* Family Planning Projects
13.224* Health Services Development-Project Grants
13.232 Maternal and Child Health Services
13.257 Alcohol Formula Grants
13.269 Drug Abuse Prevention Formula Grants
13.286 Limitation on Federal Participation for Capital Expenditures

EDUCATION

13.400 Adult Education-Grants to States
13.403* Bilingual Education
13.408, 464, 465 Library Services Programs
13.427-431, 512 Educationally Deprived Children
13.433* Follow Through
13.449 Handicapped Preschool and School Programs
13.453 Higher Education-Land-Grant Colleges and Universities
13.455 Higher Education Academic Facilities-State Administration
13.478 School Assistance in Federally Affected Areas-Maintenance and Operation
13.480 School Library Resources, Textbooks, and other Instructional Materials
13.483 Strengthening Instruction Through Equipment and Minor Remodeling
13.486 Strengthening State Departments of Education-Grants to States
13.491 University Community Service-Grants to States
13.493-495, 498-502 Vocational Education
13.519 Supplementary Educational Centers and Services, Guidance, Counseling, and Testing
13.525* Emergency School Aid Act-Basic Grants to Local Educational Agencies
13.534 Indian Education-Grants to Local Educational Agencies
13.542 Strengthening State and Local Educational Agencies-Comprehensive Planning and Evaluation
13.548 Grants to States for State Student Incentives
13.550 Postsecondary Education Statewide Comprehensive Planning Grants Program

INCOME MT. & SERVICES

13.600* Child Development-Head Start
13.609 Special Programs for the Aging
13.624 Rehabilitation Services and Facilities-Basic Support
13.626* Rehabilitation Services and Facilities-Special Projects
13.630 Developmental Disabilities-Basic Support
13.707 Child Welfare Services
13.714 Medical Assistance Program
13.754 Public Assistance-Social Services
13.761,724 Public Assistance & P. A. Training
13.748 Work Incentives Program-Child Care-Employment Related Supportive Services

* Project Grant Programs

STATUTORY & REGULATORY REFERENCES FOR PROGRAMS STUDIED-HEW

NHPRDA	Statutory References	Regulatory References	
13.210	42 USC 246	42 CFR 51.101	
13.211	42 USC 704	42 CFR 200	
13.217*	42 USC 300	42 CFR 59	
13.224*	42 USC 254 (c)		
13.232	42 USC 703	42 CFR 51 (a)	
13.257	42 USC 4572	42 CFR 54 (a)	FR 7/1/75
13.269	21 USC 1176	42 CFR 54 (b)	FR 7/1/75
13.286	42 USC 1320 a-1		FR 11/13/73
13.400	20 USC 1201	45 CFR 166	
13.403*	20 USC 8806	45 CFR 123	FR 6/24/75
13.408, 464, 465	20 USC 351	45 CFR 130	FR 12/2/74
13.427-431, 512	20 USC 241 a-m	45 CFR 116	
13.433*	42 USC 2929	45 CFR 158	FR 4/21/75
13.449	20 USC 1401	45 CFR 121	
13.453	7 USC 301	NONE	
13.455	20 USC 1132 a-4	45 CFR 170	
13.478	20 USC 236	45 CFR 115	FR 4/8/75
13.480	20 USC 821	45 CFR 117	
13.483	20 USC 441	45 CFR 141	
13.486	20 USC 861	45 CFR 119	
13.491	20 USC 1001	45 CFR 174	
13.493-495, 498-502	20 USC 1241	45 CFR 102	FR 2/25/75
13.519	20 USC 841	45 CFR 118	
13.525*	20 USC 1601	45 CFR 185	FR 6/12/75
13.534	20 USC 241 aa	45 CFR 186	
13.542	20 USC 867	45 CFR 129	
13.548	20 USC 1070	45 CFR 192	FR 5/31/74
13.550	20 USC 1142 (b)		FR 1/29/75
13.600*	42 USC 2921	45 CFR 1302	FR 6/30/75
13.609	42 USC 3021	45 CFR 903,909	
13.624	29 USC 720	45 CFR 401	
13.626*	29 USC 774	45 CFR 402	FR 12/5/74
13.630	42 USC 6061	45 CFR 416	
13.707	42 USC 620	45 CFR 220	
13.714	42 USC 1396	45 CFR 201/246/248/249	
13.754		45 CFR 228	FR 6/27/75
13.761, 724	42 USC 602/1301/1351	45 CFR 201/233	
13.748	42 USC 602	45 CFR 224	FR 9/18/75

* Project Grant Programs

FR- See Federal Register for Date shown

OTHER FEDERAL PROGRAMS

CATALOG NO.	PROGRAM	STATUTE	REGULATION
14.203	Comprehensive Planning Assistance (HUD)	40 USC 461	24 CFR 600
14.218	Community Development Grants (HUD)	42 USC 5301-17	24 CFR 570
15.605, 611	Fish & Wildlife Restoration (DOI)	16 USC 669 & 777	50 CFR 80
16.500	Comprehensive Planning Grants (LEAA)	42 USC 5601	Guideline M# 100 IE
16.502	Improving & Strengthening Law Enforcement (LEAA)	42 USC 5601	Guideline M4 100.IE
17.232	CETA I, II, VI (DOL)	PL 92-203	29 CFR 94-99
20.103	Planning Grant Program (DOT)	49 USC 1713	14 CFR 152
66.426	Waste Treatment Management Planning (EPA)	33 USC 1288	40 CFR 30, 35, 126, 130
66.600	Environmental Protection Consolidated Program Grants (EPA)	42 USC 1857, 42 USC 3251, 33 USC 1151	40 CFR 30, 35

APPENDIX II

Northwest Federal Regional Council

1321 Second Avenue · Seattle, Washington · 98101 206-442-1593

Bernard E. Kelly (HEW)
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Clifford Smith (EPA)

John Finley (OEO)

Roy Sampsel (DOI)

Stanley Trenhaile (DOA)

Reply to Attn of:
Serial No. 1745

May 23, 1975

To: FRC Principals

From: David A. Dougherty, Staff Director
NWFRC

Subject: Human Resource Planning

During the last three years, the Regional Council has undertaken several activities designed to improve the coordination of federally-funded planning programs, including the Planning Coordination Task Force and the Regional Manpower Coordination Committee.

While recognizing the need to improve the coordination of federal planning activities, the Council determined at the Port Ludlow Retreat that the two existing task force efforts had been unproductive and agreed to eliminate both activities in FY 76.

There continues to be a need for some type of interagency planning coordination effort. The fragmentation of federal planning programs has increased with the passage of major new federal legislation, including CETA, HCDA and Title XX of the Social Security Act. These, as well as other established federal programs, place a variety of planning requirements, and numerous constraints, on state and local governments which hamper their ability to carry out state and local priorities through the federally-funded planning programs.

In recognition of this problem, the regional office of HEW is planning to initiate a major review of HEW statutes and administrative regulations during FY '76 to identify provisions which restrict the ability of state and local chief executives to coordinate and integrate planning for human resource programs. As the program design for this effort has not been finalized, a specific work plan will not be available until mid or late June. At that time, it is recommended that the Council review the HEW planning coordination

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design to determine an FRC role in addressing non-HEW human resource planning programs. Given the planned HEW effort, this provides an excellent opportunity for the Council to address a critical coordination need through a focused and carefully designed approach.

9/2/75

5. Human Resources Planning. HEW/Region X is working with their headquarters in the review of programmatic planning requirements, both legislative and administrative, to determine areas of conflict and duplication. This study will lead to improving and streamlining the human resources planning process. Other federal agencies (DOL, HUD, LEAA, CSA) expressed an interest in using the analytical tools established to review their planning requirements.

ACTION: Hold exploratory meeting with key agency staff of DOL, HUD, LEAA and CSA, chaired by Norm Zimlich, to determine the degree to which other agencies will participate.

11/4/75

4. Human Resource Planning Coordination. The Staff requested direction from the Council on whether to proceed with an interagency study on federal statutory and administrative planning requirements and a determination of which departments wished to be included in the study. The Council directed the Staff to proceed with the proposed NWFRC planning study, using a questionnaire approach. This study is to include all FRC member agencies who wish to participate and all programs which they elect to include. The Study is an effort to reduce federal red tape engendered by categorical programs. A draft report is expected by December 31, 1975.

The acting Chairman stated that in view of the FRC Chairman's enthusiasm for this effort, the Council will cooperate in terms of completing the questionnaire and proceed with the study. If an agency head does not wish to participate, he should contact Mr. Kelly directly on Mr. Kelly's return to the office. A written inquiry of whether agencies wish to participate will be sent to each principal.

ACTION: Proceed with study. Prepare letter to FRC agencies.

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Clifford Smith (EPA)

John Finley (OEO)

Sampsel (DOI)

Stanley Trenholm (DOA)

Reply to Attn of:
Serial No. 1847

September 3, 1975

To: James L. Young, HUD, MS 329
James T. Hughes, DOL
John Finley, CSA
Bernard G. Winckoski, LEAA

From: Bernard E. Kelly, Chairman
Northwest Federal Regional Council

Subject: Human Resources Planning Reform Study

As discussed at the September 2 FRC meeting, HEW/Region X is sharing the leadership on a national study of HEW barriers to State and local government human resources planning. The initial step of this study involves analysis of the statutes and regulations of some 55 HEW programs. The analysis tools developed by HEW may be useful to other departments and agencies wishing to conduct a similar study.

Fernando Oaxaca indicated that OMB would be interested in the results of an interagency analysis if the FRC were to sponsor such a study across federal agencies.

The staff commitment required to conduct an analysis of your agency's programs will depend on the number of programs to be studied. HEW has assigned one full-time and one half-time staff persons to complete the analysis of the 55 programs by December 31.

Norm Zimlich (442-0490) is the HEW/Region X lead staff person on this study. He will chair a meeting in the Council Chambers on Wednesday, September 17, 10:00 a.m., to discuss the interests of other Region X agencies in such a study and the possibility of FRC sponsorship. The FRC staff will make a recommendation to the Council at the next meeting regarding such sponsorship.

If you are interested in participating in such a study, please provide Norm Zimlich by Friday, September 12, the name of your staff person who will attend the September 17 meeting.

cc: Norm Zimlich

American Revolution Bicentennial 1776-1976

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Clifford Smith (EPA)

John Finley (OEO)

Roy Sampsel (DOI)

Stanley Trenhaile (DOA)

Reply to Attn of:
Serial No. 1905

October 21, 1975

To: Ruth Kagi , DOL
Larry Fosmo, DOL
Linda Ledbetter, CSA

From: David A. Dougherty, Staff Director
Northwest Federal Regional Council

Subject: Planning Study Questionnaire

Attached for your review and comment is a draft of the planning study questionnaire which Norm Zimlich, DHEW, prepared as a result of our discussion last Friday.

Please send your comments to Norm at Mail Stop 610 by COB Monday, October 27. In the meantime, if you have any questions about the draft, please call Norm at 442-0490, or Kaye Kidwell at 442-1290.

The FRC Chairman will send the final questionnaire and other applicable information to each FRC principal for action.

Attachment

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ames L. Young (HUD)

ames T. Hughes (DOL)

ernard G. Winckoski (LEAA)

Ford Smith (EPA)

im Finley (OEO)

r Sampsel (DOI)

niey Tronhaile (DOA)

Reply to Attn of:
Serial No. 1911

October 23, 1975

To: FRC Members

From: Bernard E. Kelly, Chairman
NWFRC

Subject: Region X FRC Planning Study

There is a continuing interest among the Under Secretaries and in OMB in reducing federal red tape engendered by categorical programs. Strategies for doing so range from revenue sharing and block grants to various sorts of incremental changes in statutes, regulations and policies.

Federal "red tape" studies are under way in at least two other regions. Region V FRC has just completed a comparative study of federal formula for allocation of funds to states, covering some 42 programs in eight federal departments or agencies.

Region VIII FRC is now engaged in the development of a Single Purpose Application and Automatic Referral System (SPAARS) for some 41 federal programs in five federal departments. The aim is to simplify client-level application for assistance under these programs. The study will be completed about April 1976.

At the September Region X FRC meeting, HEW-X recommended that the Northwest FRC join HEW in conducting a broad study of federal administrative/planning requirements. The HEW study seeks to identify federal statutory, regulatory and administrative requirements which make planning difficult for State and local governments. The findings might serve as a basis for Region X FRC recommendations for incremental changes in programs or might provide hard evidence of need for further revenue sharing or block grant efforts. An FRC report would, at the very least, testify to FRC awareness of and concern over the planning problems so often cited by State and local government officials in Region X.

ATTACHMENT "C"

AMERICAN REVOLUTION BICENTENNIAL 1776-1976

At our request, staff have met twice since the last session and have developed the attached questionnaire to serve as a basis for such an FRC report. This approach greatly simplifies the in-house task of collecting information. The questionnaire could be completed in a very short time (less than one hour) by regional program staff. Each member would decide which programs in his department would be covered. The staff recommends that as many as possible of the programs studied by Regions V and VII be included (see attached comparative studies).

While some FRC members have already indicated reluctance to join such a study, I request that you reconsider in view of the light burden which completion of the questionnaire will entail. FRC staff would draft the report for review by the members. The draft report would probably be completed by December 31, 1975.

At the next FRC meeting I would hope that we can make final decision as to: (a) whether to proceed with such a study and (b) if so, with which programs.

Attachment

Northwest Federal Regional Council

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NOV 1975

Reply to Attn of:
Serial No. 1920

November 4, 1975

Bernard E. Kelly (HEW)
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Don Samuelson (DOT)
Vice Chairman

James L. Young (HUD)

James T. Hughes (DOL)

Bernard G. Winckoski (LEAA)

Clifford Smith (EPA)

John Finley (OEO)

Roy Sampsel (DOI)

Stanley Trenhaile (DOA)

To: FRC Members

From: David A. Dougherty, Staff Director

Subject: NWFRC Planning Study

At the November 4, 1975, Council Meeting, the staff was directed to proceed with the proposed NWFRC planning study, using a questionnaire approach. This study is to include all NWFRC member agencies who elect to participate, and all programs which they elect to include. Staff recommends inclusion of all the programs studied in similar efforts by the FRCs in Regions V and VIII, as well as CSA programs (see attachment).

Please inform me by COB Friday, November 14, whether your agency will participate. If so, please indicate the following:

1. The programs which you wish to be included, listed by Federal Domestic Assistance Catalog number and title,

2. Name, address, and phone of the regional agency official who should complete the questionnaire for each program (approximately one hour required).

3. Name, address, and phone of one staff person, if any, whom you are assigning to participate in the analysis of findings and preparation of the study report (5-10 workdays required during December/ January).

   Note: Whether or not a person is assigned, each participating FRC agency head will have the opportunity to review and recommend changes in the draft report.

4. Your recommendations for changes in the attached draft questionnaire.

Attachment:

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Northwest Federal Regional Council

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NOV 21 1975

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Clifford Smith (EPA)

John Finley (OEO)

Roy Sampsel (DOI)

Stanley Trenhaile (DOA)

Reply to Attn of:
Serial No. 1953

November 23, 1975

To:

J. Young	DHUD
D. Samuelson	DOT
C. Smith	EPA
M. Smith	EDA
C. Polityka	DOI
B. Kelly	HEW
B. Winckoski	LEAA
J. Hughes	DOL
J. Finley	CSA

From: David A. Dougherty, Staff Director
Northwest Federal Regional Council

Subject: NWFRC Planning Study

The above addressees have agreed to participate in the NWFRC Planning Study. The attached questionnaire will provide the basis for an NWFRC report on federal requirements which relate to planning for federally-funded programs administered by state and local governments.

One copy of the questionnaire should be completed for each program which you have decided to include. If you have not already done so, please arrange for such completion. Although some of you have forwarded the names of program participants, we would appreciate your forwarding the questionnaire to them with appropriate instructions.

We request that the completed questionnaires and one copy of any documents referenced by the answers be provided to the NWFRC office no later than December 30, 1975. Participants who have any questions may call Ms. Kaye Kidwell, FRC Representative, at 442-1290.

Thank you for agreeing to participate in this study. We expect to forward the draft report for your review about January 30, 1976.

Attachment

AMERICAN REVOLUTION BICENTENNIAL 1776-1976

NORTHWEST FRC
PLANNING STUDY
QUESTIONNAIRE

1. PROGRAM (OMB #_____) (Title)_____.
2. Statutory Reference_____.
   Regulatory Reference_____.

3. This is a_____Formula Grant_____Project Grant Program.
4. Federal funds under this program may be received by: (Check)

   _____State Gov't. _____Local Gov't.

   _____Other(describe)_____

5. The basic document required is:

   _____ State plan or plan update
   _____ Local plan or plan update
   _____ State application
   _____ Local application
   _____ Other

6. The above document is

   _____Preprint (pre-written; applicant primarily assures compliance by check-off and signature)
   _____Non-preprint (narrative; applicant describes plan or proposed activities)
   _____Partial preprint

7. Due date of plan/application last year_____.
8. Does date change from year-to-year?

   (Circle one) YES NO

9. What office determines this date?_____.
10. How is this date announced?_____
    _____.
11. When did you distribute federal funding projections to State and local grantees last year?_____.
12. When did you provide final funding availability information to grantees last year?_____.

13. National/Regional responsibilities. Please indicate whether these functions are performed by nationaloffice (D. C.), regional office, or both.

N	R	
___	___	Receives plan/application
___	___	Reviews, recommends action
___	___	Final Approval
___	___	Final Disapproval
___	___	Holds the program allowance
___	___	Issues grant award
___	___	Processes modifications
___	___	Program monitoring responsibility
___	___	Grants management responsibility
___	___	Provides planning assistance (technical assistance)

14. How do you use the plan or application? (Check all applicable items)

_____ To establish initial or continuing grant
_____ As sole basis for monitoring grantee performance and conformity to regulations
_____ As a partial basis for monitoring grantee conformity to regulations
_____ As basic information regarding State needs and priorities
_____ Other

15. Do you get more than one plan or application or more than one part, e.g., compliance plan vs service or operational plan?

_____

_____

16. Does the plan/application provide a basis for federal intervention with the grantee regarding priorities which he sets for services or recipients? _____

17. If so, is the plan/application adequate for this purpose, or must it be supplemented by other information, submittals, or reports from the grantee? _____ Adequate _____ must be supplemented

18. Has there been a substantive change of legislation affecting the planning of this program recently (since July 1, 1974)?
Yes_____ No_____

19. If so, have the final federal regulations been published?
Yes_____ No_____

20. For what do you monitor grantees?

_____ Conformity of grantee to regulations, whether or not issue is covered in plan/application
_____ Grantee performance against plan/application
_____ Conformity of plan/application to law, regulations
_____ Whether application of proposed solution is lessening the stated community problem
_____ Other

21. Roughly, what percentage of your monitoring exceptions or problems will grantees relate to the plan/application (either conformity of the plan/application or conformity of performance)_____%

22. What is the rate of federal financial participation for this program (100% - State or Local match)?_____%

If the rate is variable or several rates apply, please describe briefly. _____
_____
_____

The remaining questions seek to establish whether certain requirements apply in this program, and whether the requirements are found in the statute (S), the federal regulations (R), or other federal administrative directives (O), or in more than one such place. Complete by circling the appropriate letter(s), or by circling N/A if the statement is not applicable to this program.

EXAMPLE: An annual State Plan is required: (S) R (O) N/A.
(This answer indicates that the federal requirement for an annual State Plan is found in the statute and in administrative directives, but not in the federal regulations.)

23. The applicant must designate a Single State Agency or Sole State Agency. S R O N/A

24. The applicant must designate a Single Organizational Unit, or must otherwise have a unit whose only responsibility is the administration of this program. S R O N/A

25. The applicant must comply with certain requirements (other than or in addition to the above) relating to the organization, structure or personnel configurations of the administering agency or agencies.
S R O N/A

26. Certain planning and/or advisory committees must be established at the State and/or local level for this program.
S R O N/A

If applicable, please describe the number and type of these committees briefly or give reference to statute, regulation, etc., for further analysis._____
_____
_____

27. There are limitations on the percentage or amount of federal funds which may be expended for planning in this program.
S R O N/A

If applicable, please describe such limitations briefly or give reference to statute, regulation, etc., for further analysis.
_____
_____
_____

28. State or local planning in this program must be done by a specified agency or unit; (an example would be a requirement that planning must be done by the Single State Agency).
S R O N/A

29. Sub-state geographic areas must be designated under this program for planning or delivery of services. S R O N/A

If applicable, please describe such districting requirements briefly or give reference to statute, regulation, etc., for further analysis._____
_____
_____

30. Grantees are required to collect certain types of data about the population served, either for planning purposes or for eligibility purposes. S R O N/A

If applicable, please characterize this data briefly or provide reference to statute, regulation, etc., for further analysis.

_____

_____

_____

31. There is a State or local maintenance-of-effort requirement or similar provision requiring grantees to spend as much non-federal money as at some previous time, or precluding the displacement of State/local funds with federal funds. S R O N/A

32. There is a provision whereby the grantee may apply for waiver of certain federal requirements. S R O N/A

Please describe briefly what may be waived and by whom, or provide a reference to statute, or regulation, etc., for further analysis._____

_____

_____

33. It is the federal intent that substantive planning be done by the grantee, i.e., planning which includes (1) an analysis of needs and resources (or of market supply and demand), (2) the setting of program goals, and (3) evaluation of performance.
S R O N/A

(The following questions deal more specifically with certain elements of substantive program planning.)

34. The grantee must analyze the need for this program within the State, community, or populace. (Needs assessment/market survey)
S R O N/A

35. The grantee must analyze existing services, funds, or resources to meet that need (resource inventory/assessment of supply).
S R O N/A

36. The grantee must compare needs and resources or supply and demand for this program. S R O N/A

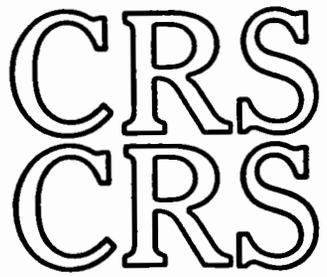
37. The grantee must set priorities for services, recipients or sub-programs, or must establish goals or objectives for the program.
S R O N/A

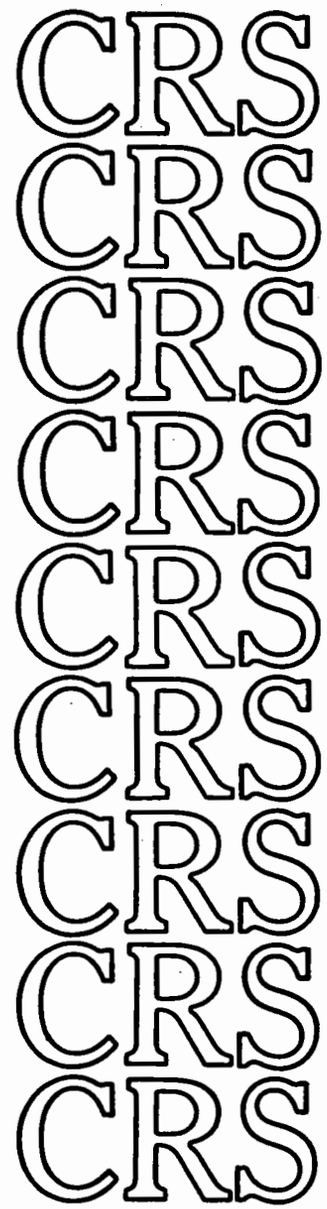
38. The grantee must allocate resources among sub-units, or must determine an appropriate "mix" or combination of service/program activities to fit the differing needs of sub-groups within the population served. S R O N/A

39. The grantee must identify needs which will remain unmet by this program, or must make a projection of long-range changes which the program will make. S R O N/A

40. The grantee must perform an evaluation of accomplishments under this program (result-measurement rather than merely process recording). S R O N/A

(END)





ISSUE BRIEF

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Norman Beckman
Acting Director

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ISSUE DEFINITION

The major health proposal of the FY77 President's budget is a legislative proposal to consolidate 16 health services grant programs, including Medicaid and Developmental Disabilities, into a single block grant to the States. The proposal is called the Financial Assistance for Health Care Act. Budgets for each of the programs involved in the consolidation plan have been requested under existing legislative authorities. If the Administration's legislative proposal for consolidation is approved by Congress, HEW then plans to consolidate the funding for each separate program into one $10 billion block grant, which will be distributed among the States by a given formula. HEW proposes to increase the block grant amount by an additional $0.5 billion per year for each of the next three years.

BACKGROUND AND POLICY ANALYSIS

Federal funding of health care programs has, in recent years, taken the form of formula grants (grants to States) or project grants (grants to individual projects or groups) that are targeted toward specific population groups (e.g., the poor, migrants) or specific health problems (e.g., alcoholism, mental illness). This categorical approach to health care funding is intended to target resources in areas of unmet needs. It has been the basic approach of the health Committees with jurisdiction over these programs (chiefly the Health Subcommittee of the Senate Committee on Labor and Public Welfare, and the Subcommittee on Health and Environment of the House Interstate and Foreign Commerce Committee).

Since 1973, the Executive Branch has attempted to simplify or diminish these 20-odd categorical health programs in an effort to increase the flexibility of funds and to increase the role of State decision-making. With the presentation of the President's Budget for FY74 in January 1973, the Executive Branch began a policy of either phasing down or phasing out many of the categorical health services delivery programs by requesting lower budgets for these programs, or by refusing to request renewal of expiring authorizations. Congress responded, in most cases, by renewing authorizations and appropriating larger sums of money than requested by the Executive Branch.

In 1973, the Executive Branch proposed a plan, Comprehensive HEW Simplification and Reform, otherwise known as the "Mega Proposal," similar to the health block grant proposal in the FY77 budget. Among other items, the "Mega Proposal" designated nine health programs (Comprehensive Health Grants to States, Alcoholism and Narcotics Addiction Project and Formula Grants, Venereal Disease, Lead Poisoning, Rodent Control, Communicable Diseases, and Medical Social Services), which would be consolidated into a single block grant. No earmarks or matching requirements were to be made on the States. The major difference between the "Mega Proposal" and the FY77 consolidation plan is that the former did not include Medicaid in the consolidation. Medicaid was to be replaced by a health insurance program, Maximum Liability Health Insurance. The stated reasons for the "Mega Proposal" reforms were to: (1) Reduce increasingly costly health program budgets; (2) end overlapping and duplicative programs--an attempt to simplify; (3) allow States to determine their priorities; and (4) restrict the Federal role in health services.

The distribution of the block grant among the States was to be through a formula based upon population, per capita income, and medical need (including incidence of alcoholism, V.D., and drug abuse). No action was taken on this proposal by the Congress or the Executive Branch.

FY77 CONSOLIDATION PLAN
(Financial Assistance For Health Care Act)

Administration's Reasons For Block Grant

The Administration's reasons for the consolidation of health programs into a block grant are to (1) improve access in FY77 to quality health care at reasonable cost, (2) control Federal spending, constrain growth of the Federal bureaucracy, and reduce Federal red tape, (3) allow States and localities to determine their own health priorities and control health care costs, and (4) achieve a more equitable distribution of Federal health dollars among the States according to populations in need.

Programs Included in the Block Grant Plan

The 16 programs that would be included, effective Oct. 1, 1976, (the beginning of FY77) are outlined below.

Medicaid. This Federal program matches State expenditures for medical care for certain low-income persons.

In the area of health services, there are six programs.

Comprehensive Health Grants to States. These are formula grants to States for public health services.

Community Health Centers. Grants are given to community health centers in primarily medically underserved areas.

Maternal and Child Health Services. These are formula grants to States for maternal and child health and crippled children's services; research and training grants; grants to pediatric pulmonary centers; and for a Sudden Infant Death information program.

Family Planning. Grants and Contracts are offered for research, training, and dissemination of information on family planning.

Migrant Health. Grants are given to health clinics for migrants.

Emergency Medical Services. Grants and contracts are given to establish emergency medical services.

In the area of alcohol, drug abuse, and mental health, there are two programs: (1) General Mental Health Centers, which provide grants to community centers providing mental health services; and (2) Alcoholism Community Programs, which provide grants to community alcoholism programs targeted toward various population groups, such as Indians, poverty populations, and drinking drivers.

Preventive health comprises four programs.

(1) Venereal Disease. Project grants for screening and research on V.D. (2) Immunization. Research and investigations for measles, rubella, polio, TB, smallpox, etc. (3) Rat Control. Grants to help communities develop rat control programs. (4) Lead-based Paint. Screening projects for children exposed to lead-based paint.

Two health resources programs are outlined below.

Health Planning. Implementation of the National Health Planning and Resources Development Act of 1974, which authorizes funding of agencies that plan for the health services and facilities needs of their communities.

Health Construction. Formula grants are provided for medical facilities renovations, correction of safety hazards, with emphasis on outpatient facilities.

Developmental Disabilities. Project and formula grants are provided for research, training, and service projects for those with developmental disabilities.

Table 1 shows the budget levels for these programs. The "Congressional Level" column includes the enacted Supplemental Bill (P.L. 94-157), and the HEW Appropriations Bill (P.L. 94-206). The "Revised" column includes the Administration's revision of the original FY76 President's Budget Request (including proposed rescissions). The "Legislative Program Offset" for 1977 includes estimated savings from the proposed consolidation legislation.

Table 1

HEALTH AGENCY PROGRAMS IN THE
FINANCIAL ASSISTANCE FOR HEALTH CARE ACT
(Budget Authority in Millions)

		1976		
Health Block Grants	1975	Congressional Level	Revised	1977
Medicaid	6,966	8,262	8,262	9,292
Comprehensive Health Grants to States	90	90	68	--
Community Health Centers	197	197	155	155
Maternal and Child Health	293	322	224	210
Family Planning	101	101	79	79
Migrant Health	24	25	19	19
Emergency Medical Services	37	37	25	25
Disease Control-Project Grants	56	41	34	34
Community Mental Health Centers	213	219	160	131
Alcohol Community Programs	104	124	80	79
Health Resources Planning	98	164	66	90
Health Resources Construction	--	--	--	--
Developmental Disabilities	54	56	54	54
Legislative Program Offset				-168
Total	8,233	9,638	9,226	10,000

FORMULA FOR DISTRIBUTION OF BLOCK GRANT AMONG STATES

Funds would be distributed according to a formula based upon the size of the States' low-income population, per capita income, and tax effort. The proposal anticipates a redistribution of health funds from the wealthier to the poorer States.

The formula would be phased-in to give States time to prepare for adjustments in the amounts that they would receive. The formula would be applied beginning Oct. 1, 1976; but with the proviso that no State would gain more than 10% of the amount it received in FY76. Amounts in excess of a 10% increase would be reallocated among the States not receiving 10%. In subsequent years, increases would be limited to a maximum of 20% over the prior year, and decreases limited to a maximum of 5%. The allocation formula used is as follows: The share of total Federal assistance going to any given State is (P)x(TE)/(PCI) divided by the sum of such weights over all States. Components are P, the number of persons in families with income less than 1.5 times the official poverty level; TE, relative tax effort; PCI, per capita income.

Table 2 (Available in hard copy only) shows the distribution of the block grant amount by State.

PROTECTION FOR FEDERAL GRANTEES

Federal grantees (community mental health centers, neighborhood health centers, alcoholism projects, etc.) would be protected from large reductions in funding during the first three years of the program by guaranteeing them at least 80% of their FY76 grant level in FY77, 50% in 1978, and 25% in 1979.

=REIMBURSEMENT AND COST-SHARING

Although no State match to the block grant would be required, the Administration would expect the States and localities to spend at least $16 billion of their own funds for health--an amount that they spent in FY76.

The States could impose any cost-sharing or reimbursement levels, or levels of premiums that they feel would be appropriate, as long as they do not prevent access to services by the target populations.

RESTRICTIONS ON EXPENDITURE OF BLOCK GRANT

Three major restrictions on the expenditure of block grant funds by the States are noted below.

Personal Health Care (Minimum 90%). At least 90% of Federal funds must be spent on personal health care services such as those covered by Medicaid and the other grants being consolidated. Services currently provided under Medicaid and the PHS grants, which States could cover at their option with block grant funds, are listed below.

Medicaid Services

Required under current law

Hospital services (inpatient and outpatient)
Physician services
Labs and X-ray services
Skilled nursing facility services for persons over 21
Screening, diagnosis, and treatment of children (includes outreach and referral services)
Family planning
Medically related Home Health Care services
Transportation to necessary medical care

Optional under current law

Private nursing services
Clinic services
Dental services
Physical therapy
Drugs
Intermediate care facility services
Mental hospital services for persons over 65
Prosthetic devices, eyeglasses, and hearing aids
Inpatient psychiatric hospital services for persons under 21
Other diagnostic, screening, preventive, and rehabilitative services
Skilled nursing facility services for persons under 21
Services of other practitioners licensed under State law PHS Grantee Services

Community Mental Health Centers
Alcoholism services
Rat control
Lead-based paint
Immunizations
Venereal disease
Comprehensive Health Centers
Family planning
Maternal and child health services
Emergency medical services
Migrant health services
Health planning, construction, and resources development

Community and Environmental Health Activities (minimum 5%) At least 5% must be spent on (1) community health protection (e.g., disease control, environmental health, health education); (2) community- based mental health services, including alcoholism and drug abuse treatment; and (3) developmental disabilities programs.

Other Health Activities (Maximum 5%). The remaining funds may be spent on other health activities, such as planning, rate regulation, data acquisition and analysis, and resources development, or for services in the other two areas noted above.

TARGET POPULATION AND ELIGIBILITY

States may establish their own definitions of eligible population. They are not required to use Federal categorical restrictions (e.g., childless couples, single persons between ages 21 and 65, and intact families may

qualify for assistance). States may not impose duration of residence requirements as a condition of participation. If changes in eligibility are made from existing State Medicaid eligibility standards, the changes must be presented for public review and comment as part of a State Plan. Services financed with the 5% community health protection, mental health and disabilities monies may be offered to all individuals regardless of income.

STATE PLAN REQUIREMENTS

A State Health Plan must be developed annually for a State to receive the Federal block grant. The Plan must be coordinated with other human service programs (e.g., Title XX), and have broad input from health interest groups. The Plan must be published for public review and comment. State Plan publication, review, and amendment procedures would be monitored by HEW. The Plan should cover (1) how the State will assure equal access for all citizens to health services, particularly underserved populations; (2) preventive health services; (3) provision of ambulatory and home-based care instead of institutional care when possible; (4) use of ambulatory care instead of inpatient services; and (5) promotion of community health.

The Plan would have two parts. (1) Part A would cover the entire State population for both publicly and privately financed health services. It would include (a) facilities and services--evaluation of supply and distribution; (b) health manpower--assessment of supply and training programs; (c) financing--analysis of sources available to State residents; and (d) health needs--evaluation, especially in medically underserved areas.

(2) Part B would cover the population and services that are covered by the Financial Assistance for Health Care Act. It would include (a) definition of eligible population; (b) definition of covered services, and rationale for any change from Medicaid services; (c) assessment of needs of the target population; (d) estimates of individuals to be served and expenditures for services; (e) geographic accessibility of services; (f) identification of those who provide services and the standards for each category of provider; (g) standards for each group of providers; (h) methods of reimbursement of providers; (i) impact of service programs on particular populations, including children, elderly, migrants, mentally ill, alcoholics, drug abusers, handicapped, and mentally disabled; (j) coordination among the block grant program, SSI, Title XX, Medicare, and the State Health Planning Activity; (k) provisions for confidentiality of information; (l) definition of the organizational structure responsible for administering the funds under the Act; (m) quality assurance systems for each type of provider; (n) State planning, evaluation, and reporting activities; and (o) system for citizen complaints and hearings.

ENFORCEMENT, COMPLIANCE, PENALTIES

States must have a mechanism for citizens to file complaints and receive a hearing. In addition, citizens may bring civil suit. HEW plans to track States' performances against their State Plans and Federal requirements, and to do a financial audit of State records yearly. If a State is not in compliance, HEW could reduce Federal payments by up to 3% for each requirement, or, if the State refuses to come into compliance, Federal funds would be terminated.

OTHER REQUIREMENTS

States must administer a certificate-of-need program that includes a review with approval or disapproval of new State institutional health care services. States must also have quality-of-care systems that include peer review. States must report on their expenditure of funds at the end of each year and explain variances from their State Plans.

FEDERAL HEALTH PLANNING ACTIVITIES

The Federal Government would establish a National Health Planning and Policy Council composed of representatives of major health interests to address nationwide health issues such as health costs, manpower, and resources allocation. HEW would develop technical assistance materials (data, analyses, and guidelines) to assist States, conduct research on the impact of health planning, and develop national guidelines on distribution of health resources.

ANALYSIS OF BLOCK GRANT PROPOSAL

The proposal to consolidate many of the health services programs has the potential of addressing many of the problems involved in the Federal financing of health programs. It also may create some new ones.

Funding Levels. The proposal should have the effect of reducing the Federal expenditures for health services through the $10 billion ceiling in FY77 and through limits on increases of $0.5 billion in the three succeeding years. The effect these ceilings will have on programs dependent upon Federal funding remains to be seen. A Federal ceiling on funds will shift responsibility to the States and localities to finance any shortfalls in ongoing or new programs. There is a question whether the States would be financially capable of supplying the necessary funds to continue support of these programs. The Federal ceiling could have the effect of encouraging individual projects (health centers, alcoholism projects, etc.) to try to become self-supporting, if possible, in the absence of Federal funds.

It is difficult to say whether the $10 billion request for the block grant is adequate for FY77. The $10 billion amount is based upon continuing most programs in FY77 at the FY76 Revised Budget level. The FY76 Revised Budget level is unrealistically low because it ignores the enacted supplemental appropriation (P.L. 94-157) and the HEW appropriation bill (P.L. 94-206). If one compares the 1977 estimate with the 1976 column, which includes these two bills (see Table 1, 1976 "Congressional Level" column), the 1977 numbers for each health program except Medicaid are, in most cases, considerably lower than 1976. Since Congress overrode the veto of the HEW bill, the Federal Government is now asking the States, in 1977, to support health programs that have been reduced 26% in total (excluding Medicaid). Instead of increasing the health budget $1 billion in FY77, the net increase will be $775 million, all of which will be used to cover the increase in the cost of the Medicaid program.

It is difficult to determine the "reasonableness" of the estimate of $9,292 million for FY77 Medicaid expenditures without more information on the source and the State-by-State distribution of the estimate. Although the FY77 estimate is $1,108 million (13.5%) higher than the FY76 levels, it may be insufficient, as the growth rate is smaller than in previous years, and the transition quarter bridging FY76 and FY77 would be expected to increase

the growth between the two years. One of the major impacts of the block grant proposal will be felt in the years following FY77, when authorizations increase by only $.5 billion each year (compared to increases of more than $1 billion in Medicaid alone in the two preceeding years). States will have to absorb any cost increases beyond this $.5 billion increase, either through increased State funding or programmatic cutbacks.

In addition, no consideration has yet been given to the effect of the proposed changes in Medicare on Medicaid expenditures. The estimated $2.2 billion savings estimated under Medicare would result in some increased costs to Medicaid, as Medicaid pays these expenses for those persons eligible under both programs.

Simplification. By consolidating 16 health programs into one, there should be some simplification in administration of health programs. Each of these programs is presently administered by separate HEW programs, often even by separate agencies; each has its own regulations, grants review procedures, fiscal policies and constraints. By merging these programs, the Administration hopes to simplify program administration by centralizing control for these programs in the States. The burden will be on the States to establish their own standards and regulations for these programs if, indeed, they wish to continue them. Whether the States would be able to simplify program administration remains to be seen.

Priority Setting. The Administration's proposal should allow the States and localities more flexibility in determining their health goals and programs. As the legislative proposal is now written (see the above list of services), there are certain broad guidelines that the States must follow in the funding of health services that should preserve what has been felt in the past to be national needs for certain health services programs. Individual States may begin to discontinue funding of programs which they believe are not of high pricrity within their State. Whether these decisions are wise or not will depend, in part, upon how effective the States' efforts are at determing their individual health needs.

LEGISLATION

H.R. 12233 (Staggers and Devine, by request)
Designed to consolidate Federal financial assistance to the 50 States, the District of Columbia, and the territories for programs on those individuals most in need of them, and to eliminate unnecessary restrictions on the exercise of State responsibility for program administration. Referred to the House Interstate and Foreign Commerce Committee.

S. 3137 (Curtis)/H.R. 12955 (Michel)
Seeks to consolidate Federal financial assistance to the 50 States, the District of Columbia, and the territories for programs in the field of health. Also focuses those programs on individuals most in need of them, and eliminates unnecessary restrictions on the exercise of State responsibility for program administration. Referred jointly to the Finance Committee and the Labor and Public Welfare Committee.

REPORTS AND CONGRESSIONAL DOCUMENTS

U.S. Congress. Senate. Committee on Labor and Public Welfare. Subcommittee on Health. Health, education and welfare

regulations for health services, 1973. Appendix: Comprehensive HEW simplification and reform ("Mega Proposal"). Hearing, 93d Congress, 1st session. Washington, U.S. Govt. Print. Off., 1974. 337 p.
Hearing held June 27, 1973.

ADDITIONAL REFERENCE SOURCES

The Budget of the United States Government, Fiscal Year 1977--Appendix. Jan. 21, 1976. Washington. U.S. Govt. Print. Off., 1976.

U.S. Department of Health, Education, and Welfare. Press Release on the FY77 Budget. Jan. 21, 1976.

TABLE 2

DISTRIBUTION OF FUNDS BY STATE FISCAL YEARS 1976 THROUGH 1986 IN MILLIONS OF DOLLARS ($)

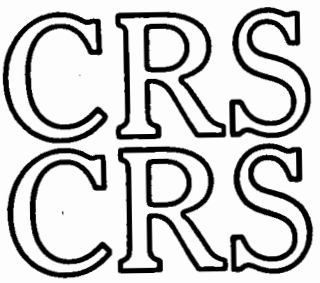
STATE	FY1976	FY1977	FY1978	FY1979	FY1980	FY1981	FY1982	FY1983	FY1984	FY1985	FY1986
ALABAMA	156.0	171.5	188.7	207.6	249.1	298.9	358.7	375.3	389.7	404.1	418.6
ALASKA	11.5	11.8	12.0	12.3	11.6	11.5	11.5	11.5	11.5	11.6	11.6
ARIZONA	12.5	13.8	15.2	16.7	20.0	24.0	28.8	34.2	41.1	49.3	59.1
ARKANSAS	111.1	122.2	134.4	147.9	177.5	213.0	225.7	234.7	243.8	252.8	261.8
CALIFORNIA	1124.8	1155.2	1173.0	1198.8	1133.5	1127.5	1126.4	1124.8	1135.3	1177.3	1219.4
COLORADO	92.1	94.5	96.0	98.1	110.4	115.2	120.0	124.8	129.6	134.4	139.2
CONNECTICUT	110.5	113.5	115.2	117.8	111.3	110.8	110.7	110.5	110.6	111.1	111.0
DELAWARE	12.9	14.2	15.7	17.2	20.7	21.7	22.6	23.5	24.4	25.3	26.2
DISTRICT OF COLUMBIA	74.2	76.3	77.4	79.1	74.8	74.4	74.4	74.2	74.3	74.7	74.6
FLORIDA	164.5	181.0	199.1	219.0	262.8	315.4	378.5	449.4	485.4	503.4	521.4
GEORGIA	235.7	259.3	285.2	313.7	359.8	375.5	391.1	406.8	422.4	438.1	453.7
HAWAII	29.3	30.1	30.6	31.2	31.8	33.2	34.5	35.9	37.3	38.7	40.1
IDAHO	31.1	34.2	37.6	41.3	43.6	45.5	47.4	49.3	51.2	53.1	55.0
ILLINOIS	458.1	470.5	477.7	488.3	461.7	459.2	458.8	458.1	458.7	462.9	479.4
INDIANA	157.8	173.6	176.3	180.1	202.2	211.0	219.8	228.6	237.4	246.2	255.0
IOWA	86.8	95.5	105.0	115.5	138.6	154.2	160.6	167.0	173.4	179.9	186.3
KANSAS	70.9	78.0	85.8	94.4	113.2	118.1	123.0	127.9	132.9	137.8	142.7
KENTUCKY	152.4	167.7	184.4	202.9	243.5	292.2	320.2	333.0	345.8	358.6	371.4
LOUISIANA	160.5	176.6	194.2	213.6	256.4	307.6	359.2	438.3	504.1	522.8	541.5
MAINE	64.4	70.9	71.9	79.1	84.5	88.2	91.9	95.6	99.2	102.9	106.6
MARYLAND	169.7	174.3	177.0	180.9	171.0	170.1	170.0	169.7	174.9	181.3	187.8
MASSACHUSETTS	354.1	363.6	369.2	377.3	356.8	354.9	354.6	354.1	354.5	356.1	355.8
MICHIGAN	461.4	473.9	481.2	491.8	465.0	462.5	462.1	461.4	462.0	464.2	468.8
MINNESOTA	193.3	198.6	201.6	206.1	215.3	224.6	234.0	243.4	252.7	262.1	271.4
MISSISSIPPI	116.4	128.0	140.8	154.9	185.9	223.1	267.7	317.9	381.4	433.4	448.8
MISSOURI	104.7	115.2	126.7	139.3	167.2	200.7	240.8	285.9	316.1	327.8	339.5
MONTANA	25.8	28.4	31.2	34.3	41.2	49.4	51.4	53.5	55.6	57.6	59.7
NEBRASKA	40.6	44.7	49.1	54.0	64.8	77.8	88.3	91.8	95.3	98.9	102.4
NEVADA	15.7	17.3	19.0	21.0	22.1	23.0	24.0	24.9	25.9	26.8	27.8
NEW HAMPSHIRE	25.7	26.4	26.8	29.5	30.8	32.2	33.5	34.8	36.2	37.5	38.9
NEW JERSEY	244.4	251.0	254.9	260.5	246.3	245.0	244.7	244.4	244.7	245.8	250.4
NEW MEXICO	34.6	38.0	41.9	46.0	55.2	66.3	79.5	94.5	113.3	136.0	151.5
NEW YORK	1666.4	1711.4	1737.8	1776.0	1679.2	1670.4	1568.8	1656.4	1668.6	1676.2	1674.8
NORTH CAROLINA	174.2	191.6	210.8	231.8	278.2	333.8	400.6	449.2	466.5	483.8	501.1
NORTH DAKOTA	21.1	23.2	25.6	28.1	33.7	38.3	39.9	41.5	43.1	44.7	46.3
OHIO	302.3	310.4	341.5	349.0	377.5	393.9	410.3	426.7	443.1	459.5	476.0
OKLAHOMA	134.6	148.1	162.9	166.5	185.4	193.4	201.5	209.6	217.6	225.7	233.7
OREGON	78.3	86.1	94.7	96.8	105.4	110.0	114.6	119.1	123.7	128.3	132.9
PENNSYLVANIA	451.9	464.1	510.5	521.8	566.8	591.5	616.1	640.7	665.4	690.0	714.7
RHODE ISLAND	60.6	62.2	63.2	64.6	61.0	60.7	60.7	60.6	60.7	60.9	59.9

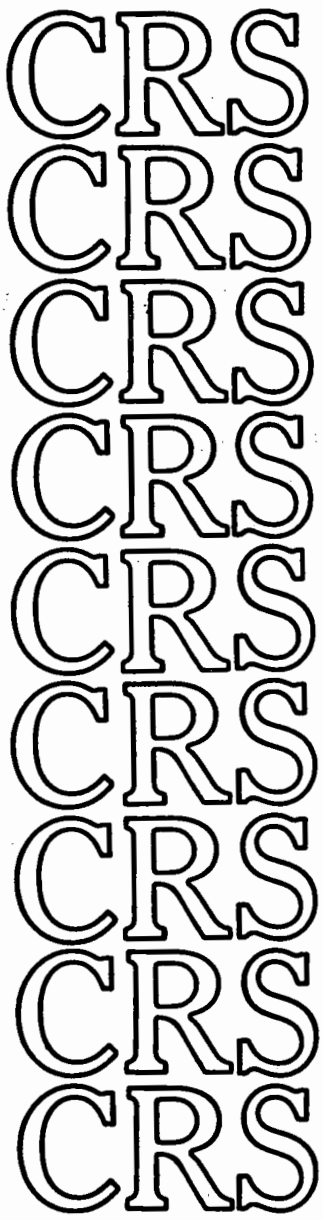
TABLE 2 (CONT.)

NET GRANT ($ MILLIONS)

STATE	FY1976	FY1977	FY1978	FY1979	FY1980	FY1981	FY1982	FY1983	FY1984	FY1985	FY1986
SOUTH CAROLINA	103.6	113.9	125.3	137.8	165.4	198.5	238.2	282.8	299.0	310.1	321.1
SOUTH DAKOTA	23.2	25.5	28.1	30.9	37.0	44.5	53.4	63.3	72.3	75.0	77.7
TENNESSEE	160.9	177.0	194.7	214.2	257.0	308.4	353.9	368.1	382.2	396.4	410.6
TEXAS	503.8	554.2	609.6	670.5	739.0	771.1	803.3	835.4	867.5	899.7	931.8
UTAH	38.6	42.5	46.7	51.4	61.7	72.8	75.8	78.9	81.9	84.9	88.0
VERMONT	32.0	32.9	36.1	36.9	40.0	41.7	43.4	45.2	46.9	48.7	50.4
VIRGINIA	140.0	154.0	169.4	186.3	223.6	265.0	276.1	287.1	298.2	309.2	320.2
WASHINGTON	137.5	141.2	143.4	146.6	138.6	138.4	144.1	149.9	155.7	161.4	167.2
WEST VIRGINIA	49.6	54.6	60.0	66.0	79.2	95.1	114.1	135.5	162.5	195.1	218.6
WISCONSIN	276.1	283.5	287.9	294.2	278.2	276.7	276.5	281.3	292.1	302.9	313.7
WYOMING	8.0	8.8	9.6	10.6	12.7	15.3	18.3	20.5	21.3	22.1	22.9
Other*		45.0	47.3	49.5	51.7	54.0	56.3	58.5	60.8	63.0	65.3
TOTALS	9466.32										
		10,000	10,500	11,000	11,500	12,200	12,900	13,500	14,050	14,550	15,000

* Puerto Rico, Virgin Islands, Guam, Am. Samoa, Trust Territories





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Acting Director

MEDICARE AND MEDICAID

ISSUE BRIEF NUMBER IB76028

AUTHOR:

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ISSUE DEFINITION

Medicare and Medicaid are the popular names given to the two programs enacted by Congress in 1965 that help aged and poor persons pay for the costs of their medical care. Medicare is a nationwide health insurance program for the aged and disabled, while Medicaid is a Federally aided State-operated and administered program for certain categories of low-income persons.

Medicare will cost an estimated $22.0 billion in FY77 -- a 23.5% increase over the $17.8 billion estimated for FY76. Medicaid outlays are expected to increase 13.1% over the same period, from $14.7 billion to $16.6 billion. The spiralling costs of these two programs and their impact on Federal and State budgets has become a subject of increasing concern. Proposals directed toward making Medicare and Medicaid both more efficient and economical are currently under consideration by the Congress.

BACKGROUND AND POLICY ANALYSIS

OVERVIEW

Medicare is a nationwide health insurance program for the aged and certain disabled individuals. The eligibility requirements and benefit structure are the same throughout the country. The program is administered by the Bureau of Health Insurance in the Social Security Administration of the Department of Health, Education, and Welfare (HEW).

Medicaid is a Federally aided, State-operated and administered program for certain categories of low-income persons. The States establish, subject to Federal guidelines, eligibility requirements and the scope of benefits to be provided. As a result, the program varies considerably from State to State. At the Federal level, Medicaid program responsibility is assigned to the Medical Services Administration in the Social and Rehabilitation Service of HEW.

Certain very-low-income aged and disabled are eligible for both programs. In cases of dual coverage, Medicaid pays for Medicare premiums, deductibles and copayments, and for services not covered under Medicare.

Federal program costs under Medicare and Medicaid are estimated at $31.2 billion for FY77, or approximately 82% of the Federal health budget. This represents a 20% increase over the $26.0 billion estimated for FY76. A little over 95% of Federal program costs represent actual benefit payments -- $24.8 billion in FY76 and $29.9 billion in FY77. States and local costs under Medicaid will represent an estimated additional $7.3 billion in FY77, a 13% increase over the $6.5 billion estimated for FY76. (See Issue Brief IB75086: Hospital Care Expenditures, Costs, and Utilization, and Issue Brief IB75004: Medical Care Prices.) Proposals directed toward making Medicare and Medicaid more efficient and economical are currently under consideration by the Congress.

Jurisdiction over Medicare and Medicaid is assigned to the Senate Finance Committee; the House Ways and Means Committee has jurisdiction over Medicare. Jurisdiction over Medicaid was transferred from the Ways and Means to the Committee on Interstate and Foreign Commerce at the beginning of the 94th Congress. Proposals affecting both programs thus require consideration by

both House committees.

The last major amendments to the Medicare and Medicaid programs were included in the Social Security Amendments of 1972 (P.L. 92-603). This legislation, which extended Medicare eligibility to certain social security disability beneficiaries and patients with chronic kidney disease who are under age 65, contained a large number of provisions designed to control costs, strengthen program administration, and improve the delivery and review of services. Cost control measures applicable to both Medicare and Medicaid included provisions limiting Federal participation for capital expenditures not approved by planning agencies, and establishing limits on hospital cost levels recognized as reasonable. The legislation eliminated the comprehensive qual requirements under Medicaid, and set limits on the prevailing charge levels for physicians' services that Medicare can recognize as being reasonable. Amendments designed to improve administration and operation included those establishing penalties for fraudulent acts and false reporting, and increasing Federal matching for improved management information systems under Medicaid. The legislation included a number of provisions directed toward improving the quality of long-term care services, including a single definition of care and coordination of certification procedures for facilities participating in both programs. P.L. 92-603 also provided for the establishment of Professional Standards Review Organizations (PSROs) throughout the country. These organizations, representing substantial numbers of practicing physicians in local areas, are charged with the ongoing review of services provided under Medicare and Medicaid. They are to determine whether services are (1) medically necessary, (2) provided in accordance with professional standards, and (3) in the case of institutional services, rendered in the appropriate setting.

During the 93d Congress, several technical measures were enacted, principally relating to the coordination of Medicaid eligibility requirements with the new Federal Supplemental Security Income (SSI) program.

P.L. 94-182, enacted on Dec. 31, 1975, included several technical amendments relating to physicians' prevailing charge levels, Medicare Part B premiums, PSRO designations and funding, and utilization review requirements under Medicaid.

In addition to proposals directed toward improved efficiency and economy, which are discussed later in this brief, a large number of bills have been introduced in the 94th Congress (as in previous Congresses) that would expand the scope of services available under Medicare, lower or eliminate certain Medicare cost-sharing charges, and improve and expand long-term care services available under Medicare and Medicaid.

MEDICARE

Description. Medicare (authorized under Title XVIII of the Social Security Act) is a nationwide program that provides health insurance to most individuals age 65 and over, to persons under 65 who have been entitled for a period of 24 months to social security or railroad retirement benefits because they are disabled, and for certain workers and their dependents who need kidney transplantation or dialysis. Medicare is a Federal program with uniform eligibility and benefit structure throughout the United States. Protection is available to insured persons without regard to their income or assets. Medicare is composed of two parts -- the Hospital Insurance Program (Part A), and the Supplementary Medical Insurance Program (Part B).

The vast majority of persons reaching age 65 are automatically entitled to

protection under Medicare Part A. Those over 65 not automatically covered may voluntarily obtain protection by paying the full actuarial cost of such coverage (currently $40 per month). Also eligible (after receiving social security or railroad retirement disabled benefits for 24 months) are disabled workers, disabled widows, and disabled dependent widowers between ages 50 and 65, beneficiaries over 18 who receive benefits because of disability prior to reaching age 22, and disabled railroad annuitants. Fully or currently insured workers under social security and their dependents with chronic renal disease may be considered disabled for purposes of coverage.

Part A is financed principally through a special hospital insurance payroll tax levied on employees, employers, and the self-employed. During calendar year 1976, each will pay a tax of 0.9% of the first $15,300 of covered earnings. During each benefit period (defined as beginning when an insured enters a hospital and ending when he has not been in a hospital or skilled nursing facility for 60 days), Part A will pay for:

(1) 90 days of inpatient hospital care subject to $104 deductible and a $26 a day copayment for the 61st through 90th day. An additional lifetime reserve of 60 days (subject to a $52 a day copayment) may be drawn upon when an individual exceeds 90 days in a benefit period;

(2) 100 days of post-hospital skilled nursing facility care subject to a $13-a-day copayment after the first 20 days;

(3) 100 medically necessary post-hospital home health visits.

Part B of Medicare is a voluntary program financed jointly through monthly premium charges on enrollees (currently $6.70) and by the Federal Government. All persons age 65 and older and all persons enrolled under Part A may elect to enroll in Part B. Persons age 65 or over who elect to "buy into" Part A are required to buy Part B protection as well. Part B (with certain exceptions) pays 80% of "reasonable charges" for the following covered services after the insured meets a $60 deductible: services of independent practitioners (primarily physicians), 100 home health visits (not subject to coinsurance), medical and related services, outpatient hospital services, and laboratory services. Radiology and pathology services that physicians provide to hospital inpatients are reimbursed without regard to the coinsurance or deductible requirements.

In general, reimbursement under the Medicare program is based upon "reasonable costs" in the case of hospitals and other institutional providers, and "reasonable charges" in the case of physicians and other noninstitutional suppliers of services.

Medicare Program Costs (in millions)

Program	FY75 (act.)	FY76 (est.)	Transitional quarter (est.)	FY77 (est.)
Hospital insurance				
total	$10,681	$12,540	$3,421	$15,468
Benefit payments	10,383	12,210	3,346	15,117
Supplementary medical				

insurance total	4,251	5,231	1,572	6,483
Benefit payments	3,781	4,706	1,437	5,910
Total Costs	14,932	17,771	4,993	21,951
Total Benefit Payments	14,164	16,916	4,783	21,027

Persons With Medicare Protection (in millions)

Protection	FY75 (act.)	FY76 (est.)	Transitional quarter (est.)	FY77 (est.)
Hospital Insurance:				
Aged	21.6	22.0	22.2	22.4
Disabled	2.1	2.3	2.4	2.5
Supplementary Medical Insurance:				
Aged	21.5	21.9	22.1	22.4
Disabled	1.8	2.0	2.1	2.2

Persons Receiving Reimbursed Services (in millions)

Services	FY75 (act.)	FY76 (est.)	Transitional quarter (est.)	FY77 (est.)
Hospital Insurance:				
Aged	4.9	5.0	1.2	5.1
Disabled	0.6	0.7	0.2	0.8
Supplementary Medical Insurance:				
Aged	11.2	11.7	3.0	12.5
Disabled	1.4	1.5	0.4	1.7

Current Program Issues. The Medicare program covers about 40% of the health costs of the aged. Various proposals have been made to extend the coverage of the program (e.g., by paying for additional long-term care, outpatient drugs, eyeglasses, hearing aids, dental care, routine physical examinations, etc.).

The substantial increase in hospital costs has prompted a number of proposals that would limit Medicare's liability in one way or another. These include incentive arrangements that would reward efficient hospitals, and, in some cases, penalize high-cost institutions; establishment of prospective payment levels based upon analysis of the hospital's proposed budget and approved needs; establishment of prospective payment levels based upon formulas; setting limits on the hospital cost increases that will be reimbursed; and the addition of copay requirements that would shift some of the hospital costs from the program to the patient. Reimbursement methods that involve prospective rates and incentives are the subject of experiments being carried out under provisions of 1967 and 1972 Medicare legislation.

Increasingly restrictive policies concerning the reasonable charges

allowable under Medicare have been accompanied by an increased unwillingness among physicians to accept the amounts payable as payment in full, and by declining assignment rates. By FY75, when about 2/3 of the bills submitted for Part B benefits were reduced because the billed amount exceeded the allowable Medicare charge, the percentage of assigned bills (on which the physician agrees to accept the allowable charge as payment in full) had fallen to 52%.

Concern has been expressed about the substantial fee differentials that exist between physicians in different localities, and that the relatively low fees sometimes paid in rural and ghetto communities, and those relatively low fees sometimes paid to general practitioners, may discourage physicians from practicing in these physician-scarce areas. Concerns over excessive payments have persisted in the case of pathologists, teaching physicians, and other practitioners who bill for services that are produced either wholly or in part by hospital employees. (The question of paying teaching physicians and the effect of Medicare payment levels on the geographical and specialty distribution of physicians was the subject of a March 1976 report by the Institute of Medicine, "Medicare-Medicaid Reimbursement Policies.")

MEDICAID

Description. The Medicaid program (authorized under Title XIX of the Social Security Act) is a Federal-State matching program providing medical assistance for low-income persons who are aged, blind, disabled, or members of families with dependent children. All States (except Arizona) and the District of Columbia, Guam, Puerto Rico, and the Virgin Islands currently participate in the program. The Federal Government's share of medical expenses is tied to a formula based upon the per capita income of the State. As a minimum, the Federal Government will pay 50% of the costs of medical care; this amount may range up to 83% in the lower per capita income States. Each State administers and operates its own program, and, subject to Federal guidelines, determines eligibility and the scope of benefits to be provided. The programs vary considerably from State to State.

Medicaid Outlays (in millions)

Costs	FY75 (act.)	FY76 (est.)	Transitional quarter (est.)	FY77 (est.)
Payments to Medical Vendors				
Federal	6,743	7,842	2,125	8,894
State	5,346	6,220	1,685	7,041
Total	$12,089	$14,062	$3,810	$15,935
Administrative Costs				
Federal	317	342	95	398
State	231	250	69	290
Total	$ 548	$ 592	$ 164	$ 688
Total Outlays				
Federal	7,060	8,184	2,220	9,292
State	5,577	6,470	1,754	7,331
Total	$12,637	$14,654,	$3,974	$16,623

Eligibility for Medicaid is linked to actual or potential receipt of cash assistance under the federally assisted Aid to Families with Dependent Children program (AFDC) and the Federal Supplemental Security Income Program (SSI) for the aged, blind, and disabled. States must cover the "categorically needy" under their Medicaid programs. In general, these are persons receiving assistance under AFDC or SSI. States have the option of limiting Medicaid coverage of SSI recipients by requiring them to meet any more restrictive eligibility standard that was in effect on Jan. 1, 1972 (before implementation of SSI). States choosing the more restrictive criteria must allow applicants to deduct medical expenses from income in determining eligibility. In 14 States, Medicaid coverage is limited to those who can meet the more restrictive criteria. Thirty-six States cover all persons eligible for SSI, and 30 States cover persons eligible for State supplementary payments under the program. States may also cover additional persons as categorically needy. These might include persons who would be eligible for cash assistance, except that they are residents in medical institutions (such as skilled nursing facilities). States may also cover the "medically needy," i.e., persons whose income is slightly in excess of the standards for cash assistance, provided that (1) they are aged, blind, disabled, or members of families with dependent children, and (2) their income (after deducting incurred medical expenses) falls below the State standard--29 States have elected this option. States may also cover all needy and medically needy children under the age of 21, even though they are not eligible for cash assistance.

Medicaid Recipients (in thousands)

Recipients	FY75	FY76	FY77
Aged	4,170	4,233	4,296
Blind	127	129	131
Disabled	2,370	2,406	2,442
Adults in AFDC families	5,100	5,304	5,410
Children under 21	10,700	11,128	11,351
Total	22,467	23,199	23,629

States are required to offer the following services under their Medicaid programs: inpatient and outpatient hospital services; laboratory and x-ray services; skilled nursing facility (SNF) services for those over age 21; home health services for those entitled to SNF care; early and periodic screening, diagnosis and treatment [EPSDT] for those under age 21; family planning services and supplies; and physicians services. They may also provide additional medical services such as drugs, intermediate care facility services, eyeglasses, inpatient psychiatric care for individuals under age 21 or over 65. States are permitted to establish limitations on the amount of care provided under a service category (such as limiting the number of days of covered hospital care or number of physician services). States may provide more in the way of services for the categorically needy than the medically needy, but they may not provide less.

States have considerable leeway in setting reimbursement levels for services except for hospital care where they are, in general, governed by the cost payment system established under Medicare. Effective July 1, 1976, States will be required to have HEW approval for reimbursement systems for skilled nursing and intermediate care facilities. Practitioners and providers are required to accept payments under the program as payment in full for covered services. Patients residing in long-term care facilities, however, may be required to turn over most of their income to help pay for the cost of their care. In certain cases nominal copayments may also be required (e.g., one dollar per prescription).

Current Program Issues. Increasing evidence of fraud and abuse, particularly on the part of health care providers, has recently become the subject of major concern. While the exact dollar figure is not available on the cost to the program of such actions, some estimates range from 5-10% of total expenditures. Violations include bill padding by doctors, kickbacks by medical laboratories, sending patients to a succession of doctors when not medically justified ("ping-ponging"), and massive swindles on the part of nursing home operators. A GAO report issued on Apr. 23, 1973, and two subsequent Congressional Committee reports highlighted both examples of fraud and abuse and HEW's alleged failure to take effective action. HEW had stated that since Medicaid is administered by the States, it is the States' responsibility to detect and prosecute violators. However, HEW is now taking more direct action. A newly established fraud and abuse unit, expected to be composed of 108 persons, is expected to assist States in identifying corruption, proceeding with prosecution, and establishing better management systems. On Mar. 26, 1976, the Secretary of HEW announced a major investigative program to be conducted over the next year in six of the States with the largest Medicaid expenditures. Program abuse and fraud in the program is not limited to providers; recipients may misrepresent their circumstances in order to obtain eligibility, or may loan their cards to noneligible persons. Recipient fraud is considered to be less extensive and far less costly than provider fraud. While there is a high instance of errors in eligibility determinations, much of the blame is placed upon the difficulty of administering the program's difficult eligibility requirements.

Rising costs of the Medicaid program have placed increasing strains on many State budgets and forced a number to take actions in response to budgetary pressures. In the first nine months of 1975, 15 States cut back in the scope of services offered or groups covered under their Medicaid plans. A number of States have also set limits on reimbursement rates for physician's services that are substantially below those authorized under Medicare; this has deterred a number of physicians from accepting Medicaid patients. The delay in the implementation of the mandatory early and periodic screening, diagnosis, and treatment program (EPSDT) has also been attributed to fiscal concerns. Despite the law's penalty for noncompliance, only 11% of the estimated 13 million eligible children were screened in FY75.

The administration of State Medicaid programs, in many instances, has been found lax and inefficient, and fails to meet Federal requirements for proper program operation. Deficiencies include delays and errors in making eligibility determinations, absence of accurate reporting systems, and inadequate procedures for reviewing claims. The Medical Services Administration, the Federal Medicaid agency, has been unable to effect significant improvements, primarily because of an absence of uniform performance standards and the lack of effective sanctions for poorly performing States.

Eligibility requirements for Medicaid are complex, vary widely between the States, and preclude certain poor persons from receiving benefits.

Eligibility is tied to actual or potential receipt of welfare; a recipient must be aged, blind, disabled, or a member of a family with dependent children. Persons who do not fall within these definitions (example: singles, childless couples, and, in some States, male-headed families) cannot receive Medicaid benefits regardless of their income. Further, a person with a specified income could be eligible automatically for benefits in one State, forced to incur substantial medical expenses before gaining eligibility in a second State, and not be eligible at all in a third State.

The scope of benefits available to recipients is generous in some States, and in other States more limited. The average Medicaid payment for families on AFDC ranged from $210 in Mississippi to $1,570 in New York in FY74. A further concern regarding services offered under Medicaid is that the primary emphasis has been on institutional care; for example, only 0.3% of program payments went for home health services in FY74. Roughly 36% of program payments is applied for care in long-term care institutions (skilled nursing facilities and intermediate care facilities). In many instances, these facilities fail to meet required standards or provide the full range of services required by the patients. The Federal Government is placing increasing emphasis on upgrading care in these institutions.

LEGISLATION

P.L. 94-182 (H.R. 10284)

Amends Title XVIII of the Social Security Act to assure that the prevailing fees recognized by Medicare for FY76 are not less than those for FY75. Extends, for 3 years, the existing authority of the Secretary of HEW to grant temporary waivers of nursing staff requirements for small hospitals in rural areas. Maintains the present system of coordination of the Medicare and Federal Employees' Health Benefits programs. Corrects a technical error in the law that prevents increases in the Medicare Part B premiums. Permits designation of additional statewide Professional Standards Review Organization (PSRO) areas under certain conditions and facilitates funding for PSROs. Requires State Medicaid plans to include a consent by the State to suit in Federal courts in actions brought by the providers of certain Medicaid services and includes a penalty for noncompliance with this requirement. Became law on Dec. 31, 1975.

P.L. 94-368 (H.R. 13501)

Extends for an additional year the current method of paying for physicians' services in a teaching hospital. Assures that physicians' prevailing charge levels recognized under Medicare shall not be less than those recognized in the preceeding year. Signed into law July 16, 1976.

S. 3205 (Talmadge)/H.R. 13080 (Duncan)

Medicare and Medicaid Administrative and Reimbursement Reform Act. Establishes a new combined Administration for Health Care Financing in HEW, headed by an Assistant Secretary for Health Care Financing, which would have responsibility for Medicare, Medicaid, and the PSRO program. Establishes a central fraud and abuse unit in the new Administration headed by an Inspector General. Establishes performance criteria for Medicaid to require timely determination and redetermination of eligibility, prompt payment of provider claims, effective review of those providing services and services provided, and timely development and reporting of program data. Establishes a new method of reimbursement for routine hospital operating costs based upon a classification system; and provides that the mechanism, to be phased in over 3 years, would provide incentive reimbursements for hospitals with costs that

are below the average and penalities for thos with costs that exceed 120% of the average. Specifies that medical specialists, such as certain radiologists, pathologists, and anesthesiologists, would be reimbursed on a fee-for-service, or other reasonable compensation basis, for services that they personally render or are provided under their direct personal supervision; and provides that for administrative and general supervision of departments performed by these specialists compensation would be on a basis comparable to what a salaried specialist receives for comparable time and work. Establishes a minimum payment rate for physicians under Medicaid at 80% of the Medicare reasonable charge for similar care or service. Encourages physicians to accept assignment under Medicare by permitting them to file simplified billing forms, assuring more timely reimbursement, and providing an administrative cost savings allowance above regular payments. Precludes automatic increases in Medicare prevailing charge levels for given services or procedures in a locality to the extent that they are more than 50% higher than the median charge in all localities in the same State. Provides that the Secretary of HEW will be the final certifying officer with respect to the eligibility of skilled nursing facilities and intermediate care facilities to participate in the program and permits States to include a reasonable factor in payments to for-profit facilities. S. 3205 was referred to the Senate Finance Committee, and H.R. 13080 was referred to the House Committee on Ways and Means.

H.R. 12233 (Staggers, by req.)/S. 3137 (Curtis, for the Administration)

Financial Assistance for Health Care Act. Consolidates 16 categorical grant programs, including Medicaid, into a single, $10 billion bloc grant to the States beginning in FY77. Increases the authorization level by $500 million for each succeeding fiscal year. Provides for the distribution of funds among the States according to a formula based primarily upon the size of a State's low-income population, with consideration also given to its per capita income and fiscal effort. Provides for a phase-in of the distribution formula and specifies that no State will receive less than it did in FY76 and no State will receive more than a 10% increase per year. Excludes any requirement for State matching of Federal payments. Protects PHS grantees from large budgetary reductions in the first three years. Requires at least 90% of Federal funds to be spent on personal health care, at least 5% on community and environmental health activities (including mental health services), and no more than 5% to be spent on other health activities such as planning, rate regulation, and resources development. Permits States broad latitude in defining the eligible population, except that personal health care services must be provided to those in the low-income category. Permits States broad latitude in setting reimbursement levels and levels for premiums or cost-sharing. Requires development annually of a State Health Care Plan including: (1) statement of health care goals and ways the Plan is directed toward meeting these goals; (2) assessment of health care resources, financing, and population needs; and (3) description of program including eligible population, services covered, specification of standards for categories of providers, reimbursement methods, and quality assurance systems. Requires public participation in planning process. Continues National Health Planning Council and technical assistance at the Federal level. H.R. 12233 was referred to the House Committee on Interstate and Foreign Commerce, and S.3137 was referred to the Senate Finance Committee and the Senate Labor and Public Welfare Committee.

H.R. 12082 (Duncan, Ky req.)

Medicare Improvements Act of 1976. Modifies current cost-sharing charges for hospital care, by requiring 10% coinsurance for each day beyond the first day of care up to a maximum of $500. Eliminates current maximum

day limitations for hospital and skilled nuring facility care. Provides for increases in Part B deductible equal to the percentage increases in social security payments. Requires copayment of 10% for hospital-based radiologists and pathoicgists. Places $250 ceiling on cost-sharing charges under Part B. Limits increases in reimbursement over the 1976 levels to 7% in the case of per diem payments to hospitals, and $5 in the case of physician fees. Referred to the House Committee on Ways and Means and Committee on Interstate and Foreign Commerce.

H.R. 12961 (Rogers)

Repeals the requirement under Medicaid added by P.L. 94-182 that requires a State's plan for medical assistance to include a provision giving consent of the State to certain suits brought with respect to payment for in-patient services. Passed the House on May 12, 1976. Referred to the Senate Finance Committee. Hearings were held on June 7, 1976.

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U.S. Congress. House. Committee on Government Operations. Department of Health, Education and Welfare (Prevention and Detection of Fraud and Program Abuse). [Washington, U.S. Govt. Print. Off.] Jan. 26, 1976. 42 p. (94th Congress, 2d session. House. Report no. 94-786.)

U.S. Congress. House. Committee on Interstate and Foreign Commerce. Subcommittee on Health and Environment. Data on the Medicaid Program: Eligibility, services, expenditures, Fiscal Years 1966-1976. [Washington, U.S. Govt. Print. Off.] January 1976. 91 p. (94th Congress, 1st session).
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U.S. Congress. Senate. Special Committee on Aging. Fraud and abuse among clinical laboratories. Washington, U.S. Govt. Print. Off., February 1976. 45 p. (94th Congress, 2d session).
At head of title: Committee print.

ADDITIONAL REFERENCE SOURCES

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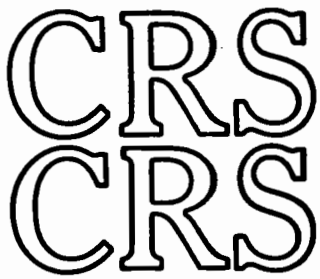
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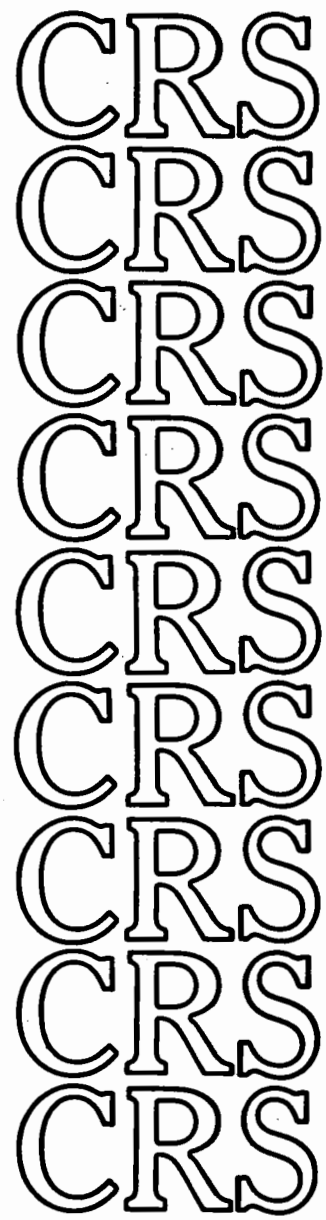
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----- An Overview of the Medicare Program [by] Robert Hoyer. [Washington] Mar. 18, 1976. 17 p.
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----- Professional Standards Review Organization (PSRO's) for review of services under Medicare and Medicaid [by] Jennifer O'Sullivan.

[Washington] Feb. 1, 1976. 37 p.
Multilith 76-37 ED





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ISSUE DEFINITION

The U.S. Supreme Court decisions in Roe v. Wade, 410 U.S. 113 (1973), and Doe v. Bolton, 410 U.S. 179, which held generally that a State could no longer prohibit abortions in the first 6 months of pregnancy, caused several House and Senate members to move for an abortion prohibition effectuated by congressional action. To this end, proposed bills and constitutional amendments have been introduced in both Houses. Rather than having settled the abortion question conclusively, the Supreme Court decisions have kindled a national protest movement.

BACKGROUND AND POLICY ANALYSIS

It is generally acknowledged that, at common law, abortion performed before quickening (the first recognizable movement of the fetus in utero) was not an indictable offense. Whether abortion of a quick fetus was a felony at common law is still disputed. The later and predominant view, however, is that abortion of a quick fetus was, at most, a minor offense.

In this country, the law in all but a few States until the mid-19th century was the pre-existing English common law. It was not until after the Civil War that legislation began generally to replace the common law. Most of these initial statutes dealt severely with abortion after quickening but were lenient with it before quickening. The typical law permitted an abortion where necessary to save the mother's life.

Gradually, in the middle and late 19th century, the quickening distinction disappeared from the statutory law of most States. By the end of the 1950s, a large majority of the jurisdictions banned abortion, however and whenever performed, unless done to save or preserve the life of the mother. The exceptions, Alabama and the District of Columbia, permitted abortion to preserve the mother's health. Three States, (Mass., N.J., and Pa.) permitted abortions that were not "unlawfully performed" or that were not "without lawful justification," leaving interpretation of those standards to the courts.

In recent years, about one-third of the States have adopted, either in whole or in part, the Model Penal Codes provisions allowing abortions in instances other than where the mother's life is in danger, i.e., where continuance of the pregnancy would gravely impair the physical or mental health of the mother; or where the child would be born with a grave physical or mental defect: or where the pregnancy resulted from rape, incest, or other felonious intercourse. By the end of 1970, four States (Alaska, Hawaii, N.Y., and Wash.) had repealed criminal penalties for abortions performed in early pregnancy by a licensed physician, subject to stated procedural and health requirements.

Beginning with the successful challenge to California's pre-1967 restrictive abortion statute, People v. Belous, 71 Cal.2d 954, 458 P.2d 194 (1969), cert. denied, 397 U.S. 915 (1970), abortion proponents in the early 1970s were successful in having abortion statutes declared unconstitutional in several States. Wielding arguments that (1) abortion statutes invade a woman's privacy and (2) that statutes prohibiting abortions except "where necessary to save the life of the mother" are unconstitutionally vague,

abortion propcnents successfully argued that abortion statutes in Texas (Roe v. Wade, 314 F. Supp. 1217 (N.D. Tex. 1970)); Georgia (Doe v. Bolton, 319 F. Supp. 1048 (N.D. Ga. 1970)); Wisconsin (Babbitz v. McCann, 310 F. Supp. 293 (E.D. Wis. 1970)); Illincis (Doe v, Scott, 321 F. Supp. 1385 (N.D. Ill. 1971)); Connecticut (Abele v. Markle, 342 F. Supp. 800 and 351 F. Supp. 224 (Conn. 1972)); New Jersey (Y.W.C.A. v. Kugler, 342 F. Supp. 1048 (N.J. 1972)); Kansas (Poe v. Menghini, 339 F. Supp. 986 (Kan. 1972)), and Florida (State v. Barquet, 262 So.2d 431 (Fla. 1972)) were unconstitutional. However, State abcrtion statutes were sustained in Louisiana (Rosen v. Louisiana State Board of Medical Examiners, 318 F. Supp. 1217 (E.D. La. 1970)); Ohio (Steinberg v. Brown's', 321 F. Supp. 741 (N.D. Ohio 1970)); Utah (Doe v. Rampton, _ F. Supp._ (D. Utah 1971)); Kentucky (Crossen v. Attorney General, 344 F. Supp. 587 (E.D. Ky. 1972)); North Carolina (Corkey v. Edwards, 322 F. Supp. 1248 (W.D. N.C. 1971)); Indiana (Cheaney v. State, 257 So.2d 876 (Miss. 1972)); and South Dakota (State v. Munson, _ S.D. _, 201 N.W.2d 123 (1972)). Indeed, even the U.S. Supreme Court denied a vagueness challenge to the District of Columbia abortion statute, U.S. v. Vuitch, 402 U.S. 62 (1971). The net effect of the Vuitch decision, however, was to expand the availability of abortions under the D.C. statute's section allowing abortions where "necessary for the preservation of the mother's...health."

Finally, on Jan. 22, 1973, the United States Supreme Court, in deciding appeals from the invalidation of Texas and Georgia abortion statutes held that a State may no longer prohibit abortions in approximately the first 6 months of pregnancy (Roe v. Wade, 410 U.S. 113 (1973)). Neither may the State encumber the abortion right with certain statutory procedural requirements (Doe v. Bolton, 410 U.S. 179 (1973), companion case with Wade).

Ruling that a woman has a fundamental personal right, encompassed by a Fourteenth Amendment right of privacy, to terminate her pregnancy, the Court in Wade held the following:

(1) For the stage prior to approximately the end of the first trimester of pregnancy, the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman's attending physician.

(2) For the stage subsequent to approximately the end of the first trimester, the State, in promoting its interest in the health of the mother, may, if it chooses, regulate the abortion procedure in ways that are reasonably related to maternal health.

(3) For the stage subsequent to viability, the State, in promoting this interest in the potentiality of human life, may, if it chooses, regulate, and even proscribe, abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother.

(4) The State may define "physician" to mean only a physician currently licensed by the State, and may proscribe any abortion by a person who is not a physician as so defined.

The Bolton decision effectively prohibits a State from processing an abortion patient in a manner more burdensome than for other patients. Bolton struck down Georgia statutory procedural requirements that an abortion be performed in a hospital accredited by the joint Commission on Accreditation of Hospitals, that the procedure be approved by the hospital staff abortion committee, and that the performing physician's judgment be confirmed by independent examinations of the patient by two other licensed physicians.

Additionally, a requirement that a woman must be a bona fide resident of Georgia before she could have an abortion in that State, was struck down.

The Supreme Court's decisions in Roe v. Wade and Doe v. Bolton left a number of important abortion-related issues unresolved. Two of the major questions remaining have been clarified by the Supreme Court in Planned Parenthood of Central Missouri v. Danforth and Danforth v. Planned Parenthood of Central Missouri, 44 U.S.L.W. 5197 (July 1, 1976). The Court held that spousal and parental consent requirements during the first trimester of pregnancy, which amount to a veto of the decision to abort a pregnancy, violate the standards of Roe v. Doe. The Court also held that a section of the Missouri abortion statute which prohibits the most commonly used safe available abortion procedure (saline amniosentesis) in the country was not a reasonable protection of maternal health. In addition, the Court struck down an entire section of the Missouri abortion statute which required a phusician to exercise a standard of care, without regard to stage of pregnancy, that would preserve the life and health of the fetus. Sections of the Missouri abortion statutes involving a flexible definition of viability, written consent of the women, and confidential report and recordkeeping requirements were upheld.

State Denial of Medicaid Benefits for Elective Abortion. All courts that have faced the issue have held such a denial unconstitutional. Wulff v. Singleton, 508 F.2d 1211 (8th Cir. 1975), reversed on procedural grounds by the Supreme Court, 44 U.S.L.W. 5213 (July 1, 1976); Doe v. Rose, 499 F.2d 1112 (10th Cir. 1974); Klein v. =Nassau County Medical Center=, 347 F. Supp. 496 (E.D.N.Y. 1972), vacated and remanded, 412 U.S. 925; Doe v. Rampton, 366 F. Supp. 189 (D. Utah 1973); =Doe v. Wohlgemuth, 376 F. Supp. 173 (D.C.W.D. Pa. 1974), aff'd on other grounds, _ F.2d _ (3rd Cir., Dec. 10, 1974), rehearing en banc granted February 1975; Roe v. Westby, 383 F. Supp. 1143 (D.S.D. 1974), vacated and remanded by the Supreme Court on Mar. 17, 1975, for consideration of statutory issue. Where the statutory issue has been considered alone, one court has held that Title XIX of the Social Security Act does not prevent a State from excluding elective abortion from Medicaid coverage (Roe v. Ferguson, 43 U.S.L.W. 2452, 6th Cir., Apr. 28, 1975). The court ordered a three-judge district court convened to consider the constitutional issues.

Regulation of Abortion Procedure. The courts have in a number of instances struck down State and local regulations on the ground they were overbroad and unconstitutionally restricted a woman's right to terminate her pregnancy. Friendship Medical Center, Ltd. v. Chicago Board of Health, 505 F.2d 1141 (7th Cir. 1974); Word v. Poelker, 495 F.2d 1349 (8th Cir. 1974); Doe v. Poelker, 43 U.S.L.W. 2450, 8th Cir., Apr. 14, 1975; Wolfe v. Schroering, 388 F. Supp. 631 (W.D. Ky. 1974).

Performance of Abortions in Public Hospitals. The courts have consistently held that public hospitals may not refuse to permit abortions (Nyberg v. City of Virginia, 495 F.2d 1342 (8th Cir. 1974), appeal dismissed and cert. denied, 95 S.Ct. 169; Doe v. Hale Hospital, 500 F.2d 144 (1st Cir. 1974), cert. denied, 43 U.S.L.W. 3411; Doe v. Poelker, 43 U.S.L.W. 2450, 8th Cir., Apr. 14, 1975; Roe v. Arizona Board of Regents, Ariz. Ct. App., Apr. 21, 1975).

Spousal and Parental Consent. Most courts have invalidated requirements of spousal and parental consent. Doe v. Gerstein, 376 F. Supp. 695 (S.D. Fla. 1973), cert. denied, 42 U.S.L.W. 3666; Doe v. Rampton, 366 F. Supp. 189, 193 (D. Utah 1973); Doe v. Bellin Memorial Hospital, 479 F.2d 756, 759 (7th Cir.

1973); Foe v. Vanderhoff, No. 74-F 418 (D. Colo., Feb. 5, 1975); Jones v. Smith, 278 So. 2d 339 (Fla. Ct. App. 1973), Doe v. Roe, 314 N.E. 2d 128 (Mass. 1974); but cf. Planned Parenthood of Central Missouri v. Danforth, 44 U.S.L.W. 5197.

Advertising. The Supreme Court held in Bigelow v. Virginia No. 73-1309, decided on June 16, 1975, that a State may not proscribe advertising regarding the availability of an abortion or abortion-related services in another State.

The 93d Congress enacted anti-abortion amendments to the following laws:

(1) Health Service Extension Act of 1973, P.L. 93-45, approved June 18, 1973, contains a conscience clause which prohibits compelling institutions and individuals that receive Federal funds to perform or participate in abortion or sterilization procedures.

(2) Foreign Assistance Act of 1973, P.L. 93-189, approved Dec. 17, 1973, was amended to prohibit use of funds to pay for the performance of abortions or to coerce any person to practice abortions.

(3) Legal Services Corporation Act, P.L. 93-355, enacted July 25, 1974, contains an amendment which limits the participation of Legal Services attorneys in abortion litigation.

In addition to the preceding anti-abortion riders, the 93d Congress added provisions to the National Research Act of 1974 (P.L. 93-348) and National Science Foundation Authorization Act of 1974 (P.L. 93-96), which prohibit the use of funds for research on human fetuses. [For more information on fetal research, see IB74095.]

The major policy questions involved in the abortion issue are as follows:

(1) How may Congress, if it so determines, override the Supreme Court's abortion decisions speedily and with precision? By statute? By constitutional amendment?

(2) Does section 5 of the Fourteenth Amendment to the Constitution authorize Congress to enact a statute which would prohibit abortions?

(3) Should Congress exercise its authority over the jurisdiction of inferior Federal courts and enact a statute which would prohibit Federal courts from hearing abortion cases? Would such a law be constitutional?

(4) What would be the collateral, and perhaps undesirable effects, if any, of a constitutional amendment which invests the unborn with certain constitutional "due process" and "equal protection" guarantees?

(5) Does Congress have the constitutional authority to fund a religious-affiliated hospital and at the same time insulate, by statute, that facility from being compelled by a court to provide its facilities for an abortion?

(6) May an individual or a private or public hospital be compelled to perform an abortion?

(7) Should the device of a discharge petition be used to disgorge

anti-abortion legislation from committees which plan no hearings on same?

(8) May Congress deny or limit the use of Federal funds to pay for abortions?

LEGISLATION

The following bills on abortion have been introduced in the 94th Congress:

P.L. 94-63 (S. 66)

Nurse Training Act of 1975. Amendment No. 333 (Bellmon) provides for the preservation of freedom of choice regarding abortion or sterilization practices in programs which are in whole or in part federally assisted. (Adopted by unanimous vote on Apr. 10, 1975.) Amendment No. 336 (Bartlett) bars the use of funds under Social Security to pay for or encourage the performance of abortions, except in cases necessary to save the life of the mother. (Tabled by a vote of 50-36 on Apr. 10, 1975.) S. 66 was passed by the Congress on July 20, 1975, over a Presidential veto.

S. 318 (Bartlett, Garn)

Provides that, notwithstanding any other provision of law, the Department of Health, Education, and Welfare is prohibited from spending or furnishing, directly or indirectly, any funds to pay for or encourage the performance of abortions, except such abortions which are necessary to save the life of the mother. The bill was introduced on Feb. 3, 1975, and was referred to the Senate Committee on Labor and Public Welfare; subsequently referred to the Senate Committee on Finance.

S. 2538 (Kennedy), S. 2360 (Eayh)/H.R. 10589 (Cohen)

Intended to insure that teenagers have a "meaningful alternative to abortion" by authorizing comprehensive health care for pregnant adolescents before and after childbirth. Hearings were held on S. 2538, the National School-Age Mother and Child Health Act, on Nov. 4, 1975.

H.R. 164, H.R. 4348 (Abzug et al.)

Provides that family planning services, supplies, and counseling, including abortions and sterilizations, be provided as an inclusion in medical care rendered in facilities of the uniformed services. H.R. 164 was introduced on Jan. 14, 1975, and was referred to the House Committee on Armed Services (subsequently assigned to the Subcommittee on Military Personnel). H.R. 4348 was introduced on Mar. 6, 1975, and was also referred to the Committee on Armed Services.

H.R. 1133 (Waggonner), H.R. 1515 (Dingell)

Withdraws jurisdiction from the Supreme Court and district courts in cases arising out of State laws regarding abortion. H.R. 1133 was introduced on Jan. 30, 1975, and was referred to the Committee on the Judiciary (subsequently assigned to the Subcommittee on Civil and Constitutional Rights). H.R. 1515 was introduced on Jan. 16, 1975, and was referred to the House Committee on the Judiciary.

P.L. 94-161 (H.R. 9005)

International Development and Food Assistance Act of 1975. Sen. Jesse A. Helms (R-N.C.) offered an amendment prohibiting the use of family planning and population funds to pay for abortion as a method of family planning. The Helms amendment was subsequently dropped by the Senate-House conference

committee. Enacted into law on Dec. 20, 1975.

H.R. 14232 (Flood)

Department of Labor and Health, Education, and Welfare Appropriation Act. Amendment introduced by Rep. Henry Hyde (R-Ill.) would provide that none of the funds appropriated under this Act could be used to pay for abortions or to promote or encourage abortions. The Senate voted to strike the amendment on June 30, 1976. The House rejected an amendment to recede from its disagreement to the amendment on Aug. 10, 1976.

Numerous proposed constitutional amendments have been introduced in the 94th Congress in an attempt to overturn the Supreme Court's decisions in Roe v. Wade, 410 U.S. 113 (1973), and Doe v. Bolton, 410 U.S. 179. Proposed constitutional amendments have been of two major types: (1) those maintaining the rights of the States, the District of Columbia, and the territories to pass laws allowing, regulating, or prohibiting the practice of abortion and (2) those guaranteeing a "right to life." Amendments introduced early in the 94th Congress include but are not limited to the following:

S.J.Res. 6, S.J.Res. 178 (Helms)

"Right to life" amendment, which states as follows: "Section 1. With respect to the right to life guaranteed in this Constitution, every human being, subject to the jurisdiction of the United States, or of any State, shall be deemed, from the moment of fertilization, to be a person and entitled to the right to life." On Sept. 17, 1975, the Subcommittee on Constitutional Amendments voted not to report S.J.Res. 6 to the full Committee on the Judiciary. On Apr. 28, 1976, the Senate voted to lay on the table a motion to proceed to consideration of S.J.Res. 178.

S.J.Res. 10 (Buckley et al.)

"Right to life" proposal, which would allow abortions if the continuation of pregnancy would result in the death of the mother. "Section 1. With respect to the right to life, the word 'person', as used in this article and in the fifth and fourteenth articles of amendment to the Constitution of the United States, applies to all human beings, including their unborn offspring at every stage of their biological development, irrespective of age, health, function, or condition of dependency. Section 2. This article shall not apply in an emergency when a reasonable medical certainty exists that continuation of the pregnancy will cause the death of the mother." On Sept. 17, 1975, the Subcommittee on Constitutional Amendments voted not to report S.J.Res. 10 to the full Committee on the Judiciary.

S.J.Res. 11 (Buckley et al.)

Provides as follows: "Section 1. With respect to the right to life, the word 'person' as used in this article and in the fifth and fourteenth articles of amendment of the Constitution of the United States, applies to all human beings, irrespective of age, health, function, or condition of dependency, including their unborn offspring at every stage of their biological development. Section 2. No unborn person shall be deprived of life by any person: Provided, however, that nothing in this article shall prohibit a law permitting only those medical procedures required to prevent the death of the mother." On Sept. 17, 1975, the Subcommittee on Consitutional Amendments voted not to report S.J.Res. 11 to the full Committee on the Judiciary.

H.J.Res. 41 (Delaney)

Provides as follows: "Section 1. No person, from the moment of conception, shall be deprived of life, liberty, or property without due process of law: nor shall any person, from the moment of conception, be denied equal protection of the laws. Section 2. Neither the United States nor any State shall deprive any human being of life on account of age, illness, or incapacity. Section 3. Congress and the several States shall have power to enforce this article by appropriate legislation." Introduced Jan. 14, 1975; referred to the Committee on the Judiciary.

S.J.Res. 91 (Scott)

"States rights" proposal. Provides that "the power to regulate the circumstance under which pregnancy may be terminated is reserved to the States. On Sept. 17, 1975, the Subcommittee on Constitutional Amendments voted not to report S.J.Res. 91 to the full Committee on the Judiciary.

H.J.Res. 96 (Whitehurst)

"States rights" proposal. Provides that nothing in this Constitution shall bar any State or territory or the District of Columbia, with regard to any area over which it has jurisdiction, from allowing, regulating or prohibiting the practice of abortion. The resolution was introduced on Jan. 15, 1975, and was referred to the House Committee on the Judiciary.

Several House resolutions have been introduced during the 94th Congress, either calling for the establishment of a committee to study the impact of the Supreme Court's abortion decisions or to poll citizens within the jurisdiction of the United States to determine their views with respect to abortion laws.

H.Res. 32 (Holt)

Creates a select committee to be composed of eleven members of the House of Representatives to conduct a full and complete study of the constitutional basis of the Jan. 22, 1973, Supreme Court decisions on abortion, the ramifications of such decisions on the power of the several States to enact abortion legislation, and the need for remedial action by Congress on the subject of abortions. The resolution was introduced on Jan. 14, 1975, and was referred to the Committee on Rules.

H.Res. 220 (Symington et al.)

Requests that each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Virgin Islands, the Canal Zone, American Samoa, and the Trust Territories of the Pacific Islands conduct a survey or study to determine the views of their citizens with respect to abortion laws. The resolution was introduced on Feb. 19, 1975, and was referred to the Committee on the Judiciary.

H.Res. 280 (Ruppe)

Authorizes the House Committee on the Judiciary to conduct an investigation and study of the decisions of the Supreme Court of the United States relating to the practice of abortion as to the effects of the decisions and the desirability of modification of the decisions through legislative action. The resolution was introduced on Mar. 6, 1975, and was referred to the Committee on Rules.

HEARINGS

U.S. Congress. House. Committee on the Judiciary. Subcommittee on Civil and Constitutional Rights. Proposed constitutional amendments on abortion. Hearings, 94th Congress, 2d session. Feb. 4, 5; Mar. 22-27, 1976. [Not yet published]

U.S. Congress. Senate. Committee on the Judiciary. Subcommittee on Constitutional Amendments. Abortion. Hearings, 93d Congress, 2d session, on S.J.Res. 119 and S.J.Res. 130. Part 1. Washington, U.S. Govt. Print. Off., 1974. 729 p.
Hearings held Mar. 6 and 7, Apr. 10, 1975.

----- Abortion. Hearings, 93d Congress, 2d session, on S.J. Res. 119 and S.J. Res. 130. Part 2. Washington, U.S. Govt. Print. Off., 1975.
Hearings held Apr. 25, May 7, June 4 and 26, July 24, Aug. 21, Sept. 12, and Oct. 8, 1974.

----- Abortion. Hearings, 94th Congress, 1st session, on S.J.Res. 6, S.J.Res. 10 and 11, and S.J.Res. 91. Part 4. Washington, U.S. Govt. Print. Off., 1976. 1001 p.
Hearings held Mar. 10, Apr. 11, May 9, June 19, and July 8, 1975.

REPORTS AND CONGRESSIONAL DOCUMENTS

N/A

OTHER CONGRESSIONAL ACTION

N/A

CHRONOLOGY OF EVENTS

08/10/76 -- The House voted, 223 to 150, to prohibit the use of funds for abortions under the FY77 Departments of Labor and Health, Education, and Welfare Appropriations bill.

08/03/76 -- The conference committee appointed to resolve differences between the House and Senate on H.R. 14232 failed to reach agreement on the Hyde amendment, which would ban the use of funds appropriated under the FY77 Labor-DHEW Appropriations bill for abortions.

06/30/76 -- The Senate voted, 58 to 28, to strike from H.R. 14232 the section barring the use of funds for abortions or to promote or encourage abortions.

04/28/76 -- The Senate defeated a proposal for immediate consideration of S.J.Res. 178, a proposed "right to life" amendment to the Constitution.

03/15/76 -- Senator Helms moved for immediate consideration by the Senate of S.J.Res. 178 (identical to S.J.Res. 6), a proposed amendment to the Constitution guaranteeing the right of life to the unborn. Objection was heard and the amendment was placed on the Senate calendar.

02/04/76 -- The House Judiciary Committee's Subcommittee on Civil and Constitutional Rights began hearings on proposed constitutional amendments on abortion. Testimony was heard from Prof. Cyril Means, New York Law School; and Prof. Joseph Witherspoon, University of Texas Law School.

09/17/75 -- The Subcommittee on Constitutional Amendments voted not to report to the full Committee on the Judiciary S.J.Res. 6, S.J.Res. 10, S.J.Res. 11, and S.J.Res. 91 that propose amendments to the Constitution relative to abortion.

06/29/75 -- S. 66 was passed by the Congress (P.L. 94-63) over a Presidential veto.

06/19/75 -- The House agreed to a conference to resolve the differences between S. 66 and H.R. 4925.

06/05/75 -- The House passed H.R. 4925, a companion bill to S. 66.

04/10/75 -- The Senate passed S. 66 with the Bellmon amendment, which provides for freedom of choice regarding abortion or sterilization in federally assisted programs.

11/26/74 -- The House and Senate agreed to H.R. 15580 as reported out of conference committee (subsequently became P.L. 93-517).

11/21/74 -- Conference committee reported out H.R. 15580 without the Bartlett amendment.

09/18/74 -- The Senate passed H.R. 15580, as amended, and adopted the Buckley amendment (No. 1881), which broadens protection for human participants in research and experimental programs.

09/17/74 -- The Senate adopted a sweeping amendment to H.R. 15580, the Bartlett amendment (No. 1859), which places a total ban on the use of funds alloted to Labor and HEW "to pay for or encourage" abortion except in instances when necessary to save the life of a mother.

07/25/74 -- The President signed into law H.R. 7824, the Legal Services Corporation Act of 1974 (P.L. 93-355), which contains an amendment limiting the availability of Legal Services attorneys for participation in abortion litigation.

07/12/74 -- The H.R. 7724 was enacted as P.L. 93-348.

06/28/74 -- The House agreed (311-10) to conference report on H.R. 7724, the National Biomedical Research Fellowship, Traineeship, and Training Act.

06/27/74 -- The House defeated an anti-abortion rider (247-123) when it approved H.R. 15580, the Departments of Labor and Health, Education, and Welfare Appropriations Act.

01/22/74 -- A march on the Capitol was made by 5,000-10,000 demonstrators protesting Supreme Court abortion decisions.

12/17/73 -- President signed S. 1443, the Foreign Assistance Act of 1973, which contains Helms amendment prohibiting the spending of funds for abortions (P.L. 93-189; 87 Stat. 714).

12/05/73 -- The Senate agreed to S. 1443 as reported out of conference with modified Helms amendment.

12/04/73 -- The House agreed to S. 1443 as reported out of conference, with modified Helms amendment.

11/30/73 -- Senator Buckley proposed an amendment to H.R. 3153 to prohibit Medicaid funds from being used to pay for abortions. The Buckley amendment was adopted.

11/29/73 -- Senator Church submitted an amendment to H.R. 3153, the Social Security Amendments of 1973, providing that recipients of certain Federal aid need not perform abortions if contrary to religious or moral beliefs (amendment was adopted).

11/27/73 -- The Conference committee on S. 2335 reported out S. 1443 with modified Helms amendment (H.Rept. 93-664 (1973)).

10/09/73 -- Rep. Froehlich introduced H.Res. 585, intended to create a House Select Committee to study the impact and ramifications of the Supreme Court abortion decision.

10/02/73 -- The Helms amendment to S. 2335 was adopted by Senate.

10/01/73 -- Senator Helms proposed to amend S. 2335, the Foreign Assistance Act of 1973, to prohibit Federal funds from being used in abortions.

09/11/73 -- Senator Buckley proposed to amend H.R. 7724 to prohibit research on fetuses. (The Senate version of H.R. 7724, as reported from the Committee on Labor and Public Welfare, omitted the Roncallo amendment; the Buckley amendment, as amended, was adopted by the Senate.)

08/16/73 -- The President signed H.R. 8510, the National Science Foundation Authorization Act, 1974, with Roncallo amendment, which prohibits fetal research.

08/03/73 -- The House agreed to H.R. 8510 as reported out of conference with Roncallo amendment.

07/27/73 -- The Senate agreed to H.R. 8510 as reported out of conference with Roncallo amendment.

07/26/75 -- The conference committee on H.R. 8510 reported out bill with Roncallo amendment reinstated (H.Rept. 93-408 (1973)).

07/10/73 -- Rep. Hogan presented motion to discharge Subcommittee No. 4 of the House Judiciary Committee from consideraton of H.J.Res. 261, a proposed consitutional amendment intended to negate the Supreme Court abortion decisions.

06/29/73 -- The Senate rejected the House version of H.R. 8510 and completely rewrote the bill, omitting Roncallo amendment.

06/22/73 -- Rep. Roncallo proposed to amend H.R. 8510, the National Foundation Authorization Act, to prohibit fetal research (amendment was adopted).

06/21/73 -- Rep. Hogan proposed to amend H.R. 7824, the Legal Services Corporation Act, to prohibit Legal Services attorneys from participating in abortion litigation (amendment was adopted).

06/18/73 -- The President signed S. 1136, the Health Programs Extension Act of 1973, containing Church amendment (P.L. 93-45; 87 Stat. 91).

06/05/73 -- The Senate agreed to H.R. 7806 and passed same as S. 1136, including Church amendment.

05/31/73 -- Rep. Roncallo proposed to amend H.R. 7724, the National Biomedical Research Fellowship, Traineeship, and Training Act of 1973, to prohibit research on human fetuses (amendment was a adopted).

-- Senator Buckley introduced S.J. Res. 119, a proposed constitutional amendment intended to negate the Supreme Court abortion decisions.

-- The House passed H.R. 7806 (companion bill to S. 1136) with modified Church amendment.

05/25/73 -- The House Committee on Interstate and Foreign Commerce reported on H.R. 7806 (companion bill to S. 1136) and included modified form of Church amendment (H.Rept. 93-227 (1973)).

03/27/73 -- Senator Church proposed to amend S. 1136, the Health Programs Extension Act of 1973, to prohibit inter alia a court from compelling a private hospital to perform an abortion because it receives funds (amendment was adopted).

03/13/73 -- Rep. Whitehurst introduced H.J. Res. 427, a proposed constitutional amendment to return the authority to regulate abortions to the States.

02/26/73 -- The U.S. Supreme Court declined to reconsider pro-abortion decisions of Wade and Bolton, 410 U.S. 959.

01/30/73 -- Rep. Hogan introduced H.J. Res. 261, a proposed constitutional amendment intended to negate Supreme Court abortion decisions.

01/22/73 -- The U.S. Supreme Ccurt announced pro-abortion decisions of Roe v. Wade, 410 U.S. 113, and Doe v. Bolton=, 410 U.S. 179.

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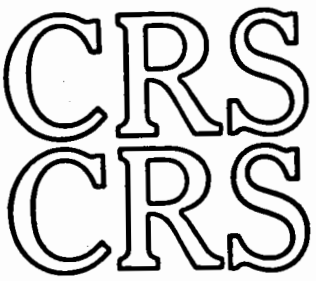
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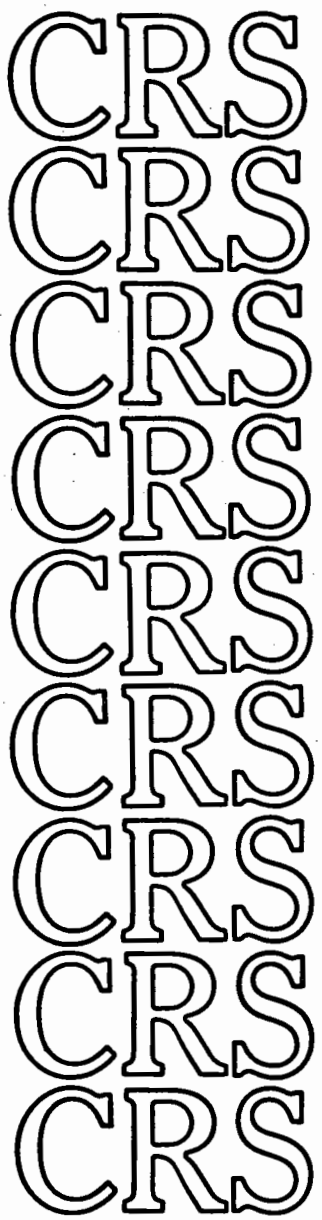
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ISSUE BRIEF

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NATIONAL HEALTH INSURANCE

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ISSUE DEFINITION

Over the past 30 years, Congress has considered a succession of legislative proposals intended to substantially alter the role of the Federal Government in providing personal health care services to the American people. These measures are loosely classified as "national health insurance," and include specific proposals having the endorsement of widely divergent groups and representing a variety of philosophies. Each plan would give the National Government more responsibility, in varying degrees, for the financing of care, the regulation of health providers, and, in some instances, the organization of the health delivery system.

BACKGROUND AND POLICY ANALYSIS

The debate over national health insurance entails examination and consideration of several interrelated issues and problems. There is, for example, a great deal of concern about the spiraling costs of medical care and about the economic burden resulting from such costs. There is also an awareness of the difficulties that many Americans have in obtaining health services even when finances are no problem. There is much discussion of the strengths and weaknesses of the various ways of organizing the delivery of medical care and developing additional health resources to meet the demands of the public for more and higher quality health care.

Renewed interest in the subject of national health insurance has developed in a growing climate of seemingly widespread public discontent with the present status of the country's health system. Major sources of this apparent dissatisfaction are: (1) sharply escalating medical care prices, (2) incomplete and partial protection against medical care expenses paid for by private health insurance, (3) inadequate protection against the costs of care associated with catastrophic illness or disease, (4) the uneven distribution of health resources and services, and (5) the absence within the health industry of incentives to improve the efficiency and effectiveness of scarce health resources. Each of these issues is discussed briefly below.

In recent years, annual expenditures in the United States for health purposes have reached astronomical proportions: $118.5 billion in FY75 (8.3% of the gross national product), which represented per capita expenditures of $547 for every man, woman, and child in the country. The national health bill has risen so rapidly that in 6 years it has nearly doubled; in 15 years, more than quadrupled; and, in the 25 years since 1950, increased more than nine-fold.

Traditionally, expenditures for health in the United States have been financed from private sources. However, beginning in FY67 with the advent of the Medicare and Medicaid programs, the trend has been toward increased public financing of health. In FY75 this trend continued, with government outlays rising two and one-half times as fast as those from private sources (22.2% compared with 7.7%). As a result, the government (Federal, State and local) share of the Nation's health bill is now more than two-fifths; in 1966, it was about one-fourth.

Following the expiration of the Economic Stabilization Program on Apr. 30, 1974, medical care prices experienced a sharp increase. For the post-control

period ending December 1974, the medical care component of the Consumer Price Index rose at an annualized rate of 14.1%. In contrast, prices for all goods and services measured by the CPI moved upward at a 12.1% annualized rate. Between May and December, the composite hospital service charges index rose at a 20.2% annualized rate, with physicians' fees increasing at a 14.4% annualized rate.

Although private health insurance has grown over the years, many Americans still have relatively little, if any, protection. In 1974, 78% of the civilian population had some form of private coverage against the cost of in-patient hospital care. While 74% of the population had private coverage for the costs in in-hospital physician visits, only 60% were insured for phsician care rendered in the home or office. Some 67% had insurance for out-of-hospital drugs, but only 33% were insured for any form of nursing home care, and 16% for dental care. Although many persons not covered under private insurance plans receive assistance for their health care expenses through public programs such as Medicare, Medicaid, and the Veterans Administration, an estimated 22 million people, or 12% of the American population, have no health insurance protection under either public or private programs.

Consumer expenditures for private health insurance in 1974 totalled $28.4 billion in premiums and subscription charges, up 12% from 1973; 8% of premium income in 1974 was returned in benefits, with 14% of the premium dollar going for operating expenses and a net underwriting loss of 1.3% of premium income.

Despite the extent of participation in private plans, private health insurance met only 40% of consumer expenditures for personal health care in 1974. In the case of hospital care, private insurance covered considerably more--77% of all consumer expenditures. But only 51% of consumer costs for physicians' care and 7% of consumer expenditures for other types of care were paid for by private insurance.

Health care costs of a catastrophic nature are among the most difficult to protect against. Although slightly more than half the population under 65 is covered under a major medical or comprehensive health plan, many of these plans contain limits on maximum benefits per episode or per lifetime that prove inadequate in the face of long-term illness or the need for exotic medical treatments. Persons without major medical or comprehensive coverage are even more vulnerable to economic ruin in the face of such expenses.

The allocation and distribution of health resources in the United States are most uneven. In some communities, virtually no hospital facilities are available to serve the public. Elsewhere, there may be a surplus of beds and other scarce manpower and equipment resources. Many institutions are old and badly in need of modernization or repair. In 133 counties of the United States, there is no active physician engaged in providing care to patients. Nearly half a million Americans reside in these counties. Generally speaking, low-income inner city areas have relatively fewer physicians than the suburbs, the rural areas less than the urban, and the poorer States less than the wealthier.

The health industry is one of the largest in the Nation, and it is also believed by its critics to be one of the most inefficient. Increasing specialization and other factors have established requirements for greater and greater numbers and kinds of manpower. There is concern over the possibly excessive use of costly hospital resources to treat persons who could be equally and more economically served in other ways. There has been criticism that the methods used to pay for health care contain little in the

way of incentivies for the economical and efficient use of facilities, manpower, and special services.

The array of national health insurance proposals reflect divergent viewpoints as to what should be considered the priority problem areas to be resolved under a national health insurance program. Most of the bills concentrate on meeting the cost problem through improved and expanded public and/or private health insurance. Other proposals incorporate provisions that would reform and restructure the health delivery system.

Several major policy questions have been raised:

(1) What is the proper role of the Federal Government in financing and administering health insurance?
(2) What portion of the population should be covered under such a program?
(3) How should the program be financed--through multiple public and private sources, or through a single channelling of funds through the public sector?
(4) What should be the nature and scope of benefits to be insured?
(5) To what extent should the private health insurance industry be involved in the program?
(6) What is the potential effect of the program on the organization and delivery of health services throughout the country?

In addition to these basic questions, other pertinent issues include such matters as the reimbursement methods and cost controls to be devised for providers of health services, provisions for consumer participation and control, and the need for quality-control procedures.

The proposals before the 94th Congress include measures that would: (1) entitle all Americans to comprehensive health benefits, federally financed and administered, (2) make the Government responsible for financing health care only for the high risks in society--the aged, poor, disabled, and persons experiencing catastrophic illness costs, (3) provide federally financed economic incentives toward the purchase of private health insurance plans, or (4) mandate employers to purchase adequate private health insurance plans for employee groups. Proponents of a federalized health insurance approach maintain that the Government is not only the appropriate, but perhaps the only institution through which universal coverage and equitable financing can be achieved and leverage can be exerted upon the health system to control costs and improve quality and efficiency in services. Supporters of more decentralized approaches advocate pluralistic financing and administration of health insurance, and would seek to minimize Government intervention in the health system.

LEGISLATION

H.R. 1 (Ullman)
National Health Care Services Reorganization and Financing Act. Establishes a program of comprehensive health benefits for all U.S.

Presidents, phased in over a 5-year period, and provides for creation of Health Care Corporations to cover every geographic area of the country. Initially, the program would extend Medicare benefits to low-income groups to be financed through general revenues, and would require employers to provide employees with private health insurance equivalent to the Medicare level of coverage. After 4 years, a broader level of benefits would be mandated for both the Federal program for the aged and the poor and the employer-employee health plans. The bill was introduced on Jan. 14, 1975, and was referred to the House Committee on Ways and Means.

H.R. 21 (Corman et al.)/S. 3 (Kennedy et al.)

Health Security Act. Establishes a federally financed and administered health insurance program for the entire population, covering a comprehensive range of services with no cost-sharing by the patient. Provides various incentives for reorganizing the delivery of health services and would act to restrain health cost increases through annual prospective budgeting on a nationwide basis. H.R. 21 was introduced on Jan. 14, 1975, and was referred to the House Committee on Ways and Means. S. 3 was introduced on Jan. 15, and referred to the Senate Committee on Finance.

H.R. 3328 (Martin et al.)/S. 600 (Brock)

Medical Expense Tax Credit Act. Provides for a system of protection against the costs of catastrophic illness by means of refundable tax credits for excessive medical expense. Allows persons to claim as credits against personal income taxes amounts equal to 85% of an amount by which medical care expenses, paid or incurred, exceed 15% of "modified adjusted gross income," as defined in the bill. Tax credits would ordinarily be claimed on the regular income tax return. H.R. 3328 was introduced on Feb. 19, 1975, and was referred to the House Committee on Ways and Means. S. 600 was introduced on Feb. 7, and was referred to the Senate Committee on Finance.

H.R. 5990 (Burleson et al.)/S. 1438 (McIntyre et al.)

National Health Care Act. Sets minimum standards to be met by private health insurance policies purchased by employers and employees, those purchased by individuals, and those offered through a State plan for the poor and near poor. Provides Federal income tax incentives for purchase of such plans by employee groups and individuals. Statewide plan for the poor would be financed by Federal and State general revenues with some premium contributions scaled to income. Both bills were introduced on Apr. 15, 1975. H.R. 5990 was referred to the House Committees on Interstate and Foreign Commerce, and Ways and Means; S. 1438 was referred to the Senate Committee on Finance.

H.R. 6222 (Fulton)

Comprehensive Health Care Insurance Act. Requires employers to make available specified private health insurance coverage for their employees and to share in at least 65% of the premium cost. The self-employed and non-employed would be eligible under the "medicredit" provisions of the bill for government contributions to private health insurance plans in the form of a credit against Federal income tax or a certificate of entitlement issued by the government and acceptable by private insurers for payment of premiums. The bill was introduced on Apr. 22, 1975, and was referred to the House Committees on Interstate and Foreign Commerce, and Ways and Means.

S. 2470 (Long et al.)/H.R. 10028 (Waggonner)

Catastrophic Health Insurance and Medical Assistance Reform Act. Creates a catastrophic health insurance program to be made available to all U.S. residents through either a federally administered public plan or would

be required under the bill to pay the full cost of catastrophic protection of their employees. Replaces Medicaid with a uniform national program of medical benefits for low-income persons. Provides for a voluntary Federal certification program for basic private health insurance to encourage private insurers to make such basic coverage (supplemental to the catastrophic plan) available in all areas of the country at reasonable rates. The bills were introduced on Oct. 3, 1975, and were referred, respectively, to the Senate Committee on Finance, and the House Committees on Ways and Means and Interstate and Foreign Commerce.

HEARINGS

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Hearings held Dec. 10-14, 1973; Feb. 1 and 2, 1974.

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At head of title: 93d Congress, 2d session. Committee print.

OTHER CONGRESSIONAL ACTION

N/A

CHRONOLOGY OF EVENTS

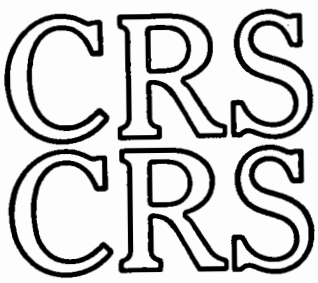
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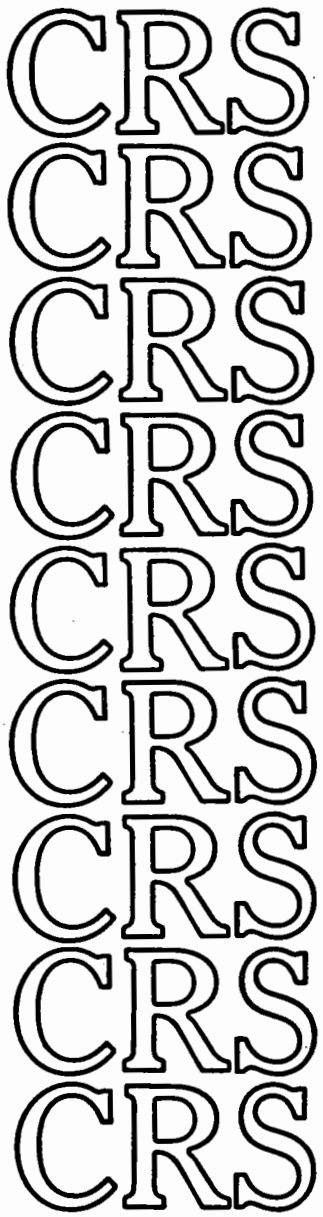
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HEALTH MANPOWER

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ISSUE DEFINITION

Health manpower shortages have existed in the United States for decades. Until recently, Federal policy has concentrated mainly on improving aggregate supplies of such manpower. While shortages of certain kinds of health professionals still exist (e.g., primary care physicians), the main issues surrounding health manpower problems are: (1) geographic maldistribution of health personnel, (2) maldistribution of physician specialists, and (3) the increasing reliance on graduates of foreign medical schools. If not solved, these problems may have considerable adverse impact on any form of national health insurance enacted by Congress.

BACKGROUND AND POLICY ANALYSIS

Nationwide shortages of health manpower have been documented and analyzed for over 30 years. As recently as 1969, the Federal Government indicated that the United States needed an additional 50,000 physicians, 200,000 nurses, and almost 150,000 technicians.

In order to alleviate some of the problems surrounding the shortage of health manpower, Congress enacted the Health Professions Educational Assistance Act in 1963, which was extended and broadened in 1965, 1968, and 1971. The programs authorized under this legislation were specifically designed to: (1) increase aggregate supplies of health manpower, mainly by increasing enrollments and graduates at health professions schools, (2) provide a stable base of revenue to the educational institutions in order to maintain their financial viability, and (3) encourage specific developments at the individual institutions including curriculum improvements, more intensive efforts to recruit minorities, and experiments to train new kinds of personnel such as physician extenders.

Most agree that the Health Professions Educational Assistance Act has been relatively successful. Enrollments and graduations at U.S. medical schools have increased substantially since the Health Professions Educational Assistance Act was enacted. First-year enrollments in medical schools increased from almost 9,000 to nearly 14,000. They are expected to increase to 15,500 by academic year 1977-78. During the decade from 1963 to 1973, graduations increased from 7,300 to 10,500.

In 1974, the Administration declared that the nation's aggregate shortage of health manpower, particularly with respect to physicans and nurses, was rapidly ending. President Nixon put it this way in his February health message to Congress: "The Nation's total supply of health professionals is becoming sufficient to meet our needs during the next decade. In fact, over-supply in the aggregate could possibly become a problem."

However, needs for health manpower cannot be dealt with solely in terms of aggregate supply. Reliable data are not currently available to reflect accurate requirements for such manpower in relation to the various populations served, demands for care, and the availability and accessibility of health services. However, if one defines the shortage in terms of the availability and accessibility of care to various segments of the population, then the reality of the shortage is apparent and can be summed up as follows:

(1) The supply of health professionals is maldistributed geographically.

(2) Physicians are maldistributed by specialty.

(3) Increasingly, the Nation is relying on graduates of foreign medical schools to provide its health care.

Geographic Distribution. Medicine is the most intensively studied health profession and the profession for which statistics and other data are most available and reliable. These statistics show that physicians are disproportionately located in the Northeast and West. These regions have ratios of active physicians per 100,000 population which are significantly above those in the South and North Central States. For every 100,000 persons in South Dakota, there are only 71 physicians providing patient care. In other words, each physician in South Dakota serves more than 1,400 people. There are 77 physicians per 100,000 population in Mississippi, or approximately 1,300 persons for each active physician. In contrast, the ratio for New York State is 195 physicians per 100,000 population, or just over 500 persons per physician. California has a rate of 168 per 100,000, or one physician for every 595 persons.

Each of these ratios reflects a significant deviation from the national average, which is 130 physicians per 100,000 population, or one physician for every 769 persons. More important, the geographical pattern indicated by these ratios reflects the continued movement of physicians to States and regions which have large urban populations, where specialized facilities and technical personnel are more readily available, where most internship and residency programs are located, and where cultural and social advantages are less limited.

Physicians, while maldistributed within regions and States, are also maldistributed within inner city, rural, and suburban areas. Latest statistics indicate that 54.8% of the Nation's physicians are located in the most densely populated metropolitan areas and serve the needs of 41.4% of the resident population. In contrast, only 7.3% of the supply of physicians is located in nonmetropolitan areas to serve the needs of 17% of the population. The number of physicians in inner cities has actually decreased over the past two decades. A recent survey of Chicago shows that the private office-based physician-population ratio in the inner city decreased from 1.11 per 1,000 in 1950 to .75 per 1,000 in 1970. Simultaneously, the same physician-population ratio in the suburbs of Chicago increased from .95 per 1,000 to 1.23 per 1,000.

Distribution by Specialty. In addition to being maldistributed geographically, physicians are maldistributed by specialty. The proportion of physicians in specialties has increased rapidly in the last two decades. In 1949, 50% of the Nation's physicians were in general practice. By 1970, the percentage had decreased to 21.8. Correspondingly, physicians in medical specialties had increased from 11.2% in 1949 to 24.3% in 1970. The percentage of physicians in surgical specialties increased during that same period from 17.1 to 27.2%. Most physicians in specialties practice in large urban areas. In 1973, 87.9% of all medical specialists providing patient care were located in the Nation's most highly populated areas. In that same year, 84.1% of the physicians in surgical specialties were located in such areas.

Reliance on Foreign Medical School Graduates. The problem of physician maldistribution is seriously aggravated by the Nation's continued and

increasing reliance on graduates of foreign medical schools (FMGs) to provide health care in the United States.

The number of FMGs entering the United States has increased remarkably during the last 14 years. In 1959, FMGs comprised less than 6% of all physicians in the United States. By 1963, that percentage had increased to 10.7. Today it is 20%. Recent Department of Health, Education, and Welfare projections indicate that by 1990 the proportion of FMGs practicing medicine in the United States could be as high as 30%.

In 1972, one-fifth of all physicians (68,009) in the United States were graduates of foreign medical schools. One-third of all interns, residents, and other physician trainees (21,959) in U.S. hospitals were FMGs. Almost half, or 46%, of all physicians newly licensed to practice in 1972 were FMGs.

Like U.S. graduates, the great majority of FMGs are specialists. Only 10% of the FMGs in the United States, as of Dec. 31, 1972, were in general practice.

The health professions legislation expired June 30, 1974, and new authorizing legislation was considered by Congress. The major questions under study were:

(1) What is the proper role of Federal support for health manpower education? Should major emphasis be placed on increasing aggregate supplies of manpower, providing stable revenues at educational institutions, and improving curricula? Should main concentrations of aid be targeted toward improving supplies of those specific professions in short supply, as well as improving the distribution of health manpower nationwide?

(2) Should Federal assistance be used to support graduate medical training programs in order to influence specialty distribution of physicians and other health professionals?

(3) Should the Federal Government continue to provide special student assistance programs for health professions students? Should these programs be tied to a health manpower shortage and service commitment for students receiving such aid?

(4) How can Federal aid be used to encourage the effective recruitment of minority and disadvantaged students?

(5) Should emphasis be placed on developing reliable data systems for determining the nature and extent of national and regional need for health manpower?

The 93d Congress enacted legislation extending the funding authority for 1 year for Federal loans to nursing and other health professions programs at their FY 1974 appropriations levels.

LEGISLATION

H.R. 5546 (Rogers et al.)

Revises and extends the Public Health Service Act programs for health professions education for 3 fiscal years. Extends and amends the construction grants program and the loan guarantee and interest subsidy programs. Establishes a program of traineeships in schools of public health, and extends and amends the student loan program, the National Health Service

Corps, and the Public Health and National Health Service Corps Scholarship program. Extends and amends the programs for capitation grants, start-up assistance and financial distress grants, special project grants, and contracts and grants for public and allied health personnel. Passed by the House on July 11, 1975, and referred to the Senate Committee on Labor and Public Welfare.

P.L. 94-63 (S.66)

Nurse Training Act of 1975. Title I revises and extends the Public Health Service Act programs of assistance for nurse training. Extends and amends the programs of construction grants, capitation grants, and financial distress grants. Reauthorizes programs of special project grants and contracts and advanced nurse training, and establishes nurse practitioner programs. Extends and amends the programs of traineeships and student loans. Passed by a House-Senate conference committee on July 11, 1975. Presidential veto was overridden in the Senate (65-15) and in the House (384-43); became P.L. 94-63 on July 29, 1975.

S. 989 (Kennedy et al.)

Health Professions Educational Assistance Act. Revises and extends the programs of Federal support for health and allied health manpower contained in the Public Health Service Act. Extends and amends the construction grant program and the construction loan guarantee and interest subsidy program. Extends and amends the health professions student loan program, and the provisions for loan forgiveness for service in designated underserved areas. Repeals the unconditional health professions scholarship program, and extends and amends the Public Health and National Health Service Corps Scholarship Training Program and the National Health Service Corps program. Extends and amends the program of capitation grants to health professions schools, requiring each health professions student enrolled in a school receiving a capitation grant to agree to serve designated underserved populations or institutions for at least 2 years after graduation, if selected for such service. Extends and amends the special project grant programs, the program of assistance to area health education centers, and the family medicine grant programs. Extends and amends the programs for allied health training. Authorizes a new national program to certify postgraduate physician training programs. Authorizes a new national licensure program for physicians and dentists. Referred to the Committee on Labor and Public Welfare.

S. 990 (Kennedy et al.)

Identical to House-passed bill (H.R. 17084) in the 93rd Congress. (See summary of H.R. 5546.)

S. 991 (Kennedy et al.)

National Health Services Manpower Act. Replaces existing Public Health Service Act programs for health professions education, allied health training, nursing, and schools of public health. Establishes a program to provide, as an entitlement, a scholarship for graduate level health professions students who would agree to serve in the National Health Service Corps for at least 2 years. Revises the National Health Service Corps Program. Establishes a national program to certify postgraduate training programs for physicians. Authorizes special project grant programs for schools of podiatry, nursing, pharmacy, public health, health administration, and allied health. Revises the program of grants to area health education centers. Authorizes loan guarantees and interest subsidies for students in health education undergraduate training programs. Referred to the Committee on Labor and Public Welfare.

S. 992 (Kennedy et al.)/H.R. 3279 (Rogers et al.)

The Health Manpower Act. Introduced at the request of the Association of American Medical Colleges. Revises and extends the program of Federal support for health manpower contained in the Public Health Service Act. Extends and amends the construction grant program and the construction loan guarantee and interest subsidy program. Extends and amends the health professions student loan program and the provisions for loan forgiveness for service in designated underserved areas. Extends the health professions scholarship program, amending it to make it a 2-year scholarship program. Extends and amends the Public Health and National Health Service Corps Scholarship Training Program and the National Health Service Corps program. Extends and amends the capitation grant program, the special project grant program, and the program of assistance to area health education centers. Authorizes a new program to certify medical residency training programs. Amends the immigration laws to require foreign medical graduates to pass certain tests before being admitted to the United States to practice medicine. S. 992 was referred to the Senate Committee on Labor and Public Welfare. H.R. 3279 was referred to the House Committee on Interstate and Foreign Commerce.

S. 1357 (Beall et al.)

Health Professions Educational Assistance Act. Revises and extends Public Health Service Act programs for health professions education, allied health, and schools of public health for 3 fiscal years. Extends and revises the construction grants program. Extends the construction loan guarantee and interest subsidy program. Extends and revises the health professions student loan program. Revises the student loan forgiveness program. Repeals the health professions scholarship program and replaces it with the Public Health and National Health Service Corps Scholarship Training Program, renaming it the Health Service Shortage Area Scholarship Program. Extends the Physician Shortage Area Scholarship Program. Extends and revises the National Health Service Corps Program, the capitation and special projects grants programs for health professions schools, and the program of assistance to area health education centers. Obligates one-fourth of the health professions students enrolled in a school receiving a capitation grant to serve in a health manpower shortage area for at least 2 years. Extends the start-up assistance program and the family medicine grant program. Repeals the computer technology grant program and the health professions teaching personnel grant program. Revises and extends the programs for allied health training. Amends the immigration laws to require foreign medical graduates to pass certain tests before being admitted to the United States to practice medicine. Referred to the Senate Committee on Labor and Public Welfare.

S. 2748 (Kennedy et al., for the Administration)

Health Professions Education Amendments of 1975. Revises the programs of Federal support for health manpower contained in the Public Health Service Act. Repeals the authority of grants for the construction of medical teaching facilities. Extends the authority for the Federal guarantee of loans for the construction of teaching facilities. Terminates the loan guarantee authority for schools of pharmacy. Repeals the program of interest subsidy payments, but would continue to make payments under previous commitments. Amends title XVI of the PHS Act to authorize States to use Federal formula allotments, loans, loan guarantees, and interest subsidies for the modernization necessary to increase the primary care health-manpower-training capacity of hospitals and outpatient facilities affiliated with a medical, osteopathic, or dental school. Phases-out "capitation" grant support, and eliminates such grants for schools of pharmacy. Replaces "capitation" for schools of medicine, osteopathy, and

dentistry, meeting specified criteria, with National Priority Incentive Grants. Replaces Public Health and National Health Service Corps scholarship training programs with a new Health Service Scholarship Program, authorizing scholarships for health professions students who agree to specified service obligations after graduation. Repeals the unconditional health professions scholarship program. Revises and consolidates special projects and financial distress authorities. Referred to the Senate Committee on Labor and Public Welfare.

S. 3239 (Kennedy et al.)

Revises and extends the programs of Federal support for health and allied health manpower contained in the Public Health Service Act. Amends the construction grant authority to substitute authority for grants to public or nonprofit private entities to assist in construction of ambulatory, primary care teaching facilities for the training of physicians and dentists. Extends authorities for loan guarantee and interest subsidies for construction of health professions teaching facilities. Revises health professions loan program. Shortage area repayment provision amended to apply only to direct health profession student loans. Establishes a program of insured loans for health professions students. Amends the health professions scholarship program to provide students of exceptional financial need with assistance for their first year of postbaccalaureate study only. Establishes a Lister Hill scholarship program for medical students who agree to enter family practice of medicine in a shortage area. Extends and amends the National Health Service Corps authority and the National Health Service Corps scholarship program. Extends and revises the capitation grant program and the special project grants authority. Establishes a National Council on Postgraduate Physician Training to conduct studies relevant to postgraduate training of physicians and establish numerical goals for distribution of training positions among specialities. Amends provisions of the Immigration Act relating to foreign physicians wishing to enter the U.S. as immigrants. Directs the Secretary of HEW to develop and establish model standards for State licensure of physicians and dentists. Authorizes grants for the establishment of occupational health training and education centers. Amends Title III of the PHS Act to provide for Federal minimum standards for licensure of radiological technologists and for the accreditation of programs for the training of radiological technologists. Passed by the Senate on July 1, 1976, and referred to conference with House-passed bill H.R. 5546.

HEARINGS

N/A

REPORTS AND CONGRESSIONAL DOCUMENTS

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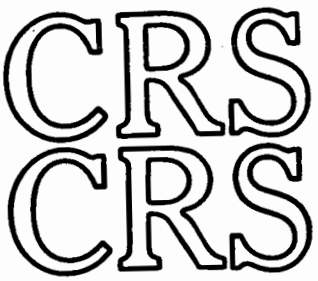
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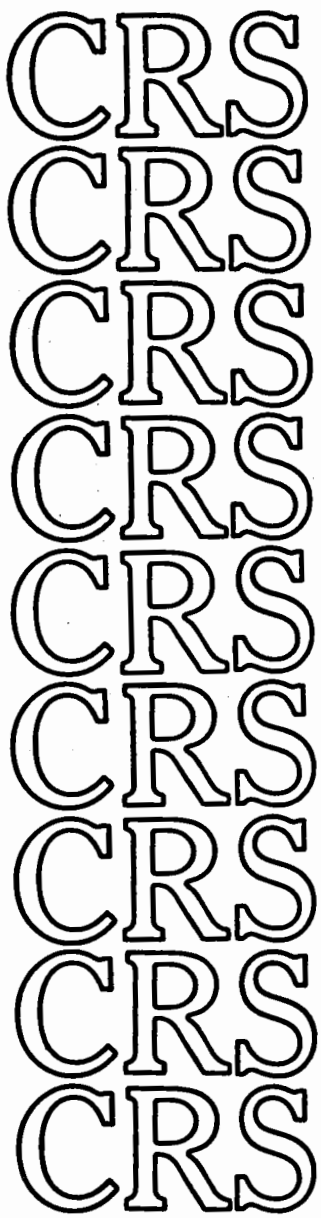
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CHRONOLOGY OF EVENTS

N/A





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MEDICAL MALPRACTICE

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ISSUE DEFINITION

Medical malpractice has become a matter of national concern because of dramatic increases in the cost of medical malpractice insurance for health care professionals in the last 15 years and the reduction in the number of insurers willing to offer medical malpractice insurance to health care professionals, particularly physicians. Physicians, as groups and individuals, in many instances are faced with the possibility of being unable to obtain coverage. This, in turn, creates a situation where patients injured through the negligence of health care providers might not be able to obtain adequate compensation for such injuries. Reviews of medical malpractice by Congressional Committees and the Administration have uncovered serious deficiencies for both the patient and the health care professional that go beyond the problems with medical malpractice insurance.

BACKGROUND AND POLICY ANALYSIS

Black's Law Dictionary gives this definition of malpractice:

"As applied to physicians and surgeons, this term means, generally, professional misconduct towards a patient which is considered reprehensible either because immoral in itself or because contrary to law or expressly forbidden by law.

"In a more specific sense, it means bad, wrong, or injudicious treatment of a patient, professionally and in respect to the particular disease or injury, resulting in injury, unnecessary suffering, or death to the patient, and proceeding from ignorance, carelessness, want of proper professional skill, disregard of established rules or principles, neglect, or a malicious or criminal intent. Rodgers v. Kline, 56 Miss. 816, 31 Am.Rep. 389; Hibbard v. Thompson, 109 Mass. 288; Napier v. Greenzweig, C.C.A.N.Y., 256 F. 196, 197."

Data available since 1960 show rapid increases in these areas: (1) the number of malpractice claims, (2) the amounts paid to injured patients or their legal representatives, and (3) the medical malpractice insurance premiums which health care providers, particularly physicians, must pay. (In this context, "legal representatives" are persons making claims on behalf of injured patients or on behalf of those suffering losses as a result of alleged injuries.) Between 1960 and 1970, malpractice insurance premiums for dentists rose 115%; for hospitals, 262.7%; for physicians other than surgeons, 540.8%; and for surgeons, 949.2%. Available evidence since 1970 shows that malpractice insurance rates are continuing to climb. In early 1974, physicians in New York State had to pay 93.5% more for their malpractice insurance than in the previous rating period. In 1975, the insurer, Argonaut, proposed an additional increase of 200%. Unable to obtain approval for the increase, it withdrew converage for over 20,000 doctors in the State. In Maryland, St. Paul Companies requested a 48% increase only a few months after having increased its rates by 46%. Unable to obtain the increase, it also withdrew its coverage for the majority of the States' physicians. California physicians have engaged in work slowdowns twice during the last nine months in protest over rising medical malpractice insurance rates. Doctors in northern California recently were forced to pay over 300% more for their medical malpractice insurance or face the loss of

coverage.

A recent survey of hospitals conducted by Malpractice Lifeline, a newspaper devcted to prcfessicnal liability issues, found that 90% of the hospitals surveyed reported a rise in their medical malpractice insurance rates in the last 3 years. For 1974-75, the increases averaged 198%, and for 1975-76, the increase was 185%. Sixty-one percent of the hospitals surveyed said they had raised their rates to absorb the increase in medical malpractice insurance. The average increase, according to the survey, was $4.56 a day, while some hcspitals raised their rates as much as $25 a day.

According to an article in the Ncv. 4, 1974, issue of the American Medical News, the number of malpractice claims filed has increased by 8 to 9% per year. The Insurance Services Office, an independent rating organization, reported in 1966 that 1.7 physicians per 100 were sued; by 1972, 3 physicians per 100 were sued. In 1970, the average (mean) settlement of malpractice claims was $5,000; by 1973, the figure had increased to $8,000. A recent survey by the American Insurance Association showed the average total award per claim to be $10,972.

Although the ccst of malpractice insurance has increased dramatically, only a small portion of these dollars actually goes to the injured patient or his legal representative. The amcunt of premium dollars actually awarded to the patient or his legal representative may range from 16 to 38 cents, depending upon which estimate is accepted. The remainder goes to lawyers for the plaintiff and the defendant, and for costs and profits of insurers. The survey by the American Insurance Association showed that settlements are frequently not prompt. The average time of settlement from the time of the incident to payment was 30 months. Settlements with larger awards took considerably lcnger. After four years, 82% of the claims are closed, but only 66% of the total dollar awards are paid. After six years, almost 6% of the claims have not been settled. Forty-nine percent of the total claims made resulted in payments to the plaintiff.

A major prcblem from several standpoints is the contingent fee system for paying the claimant's lawyer; the most common charge is one-third of the recovery amount, with both higher and lower rates used. This can result in cases beinc rejected by lawyers because the potential return is too small to justify their investment of time. A study for the Secretary's Commission on Medical Malpractice, sponsored by the U.S. Department of Health, Education, and Welfare, reported that 23% cf the claims rejected by lawyers specializing in medical malpractice were rejected because the potential dollar settlements were too small. For lawyers surveyed who had ever closed a medical malpractice case, there was a 10% rejection rate. This system can also result in excessive payments to lawyers in cases of very large awards, resulting in less mcney qcing tc the claimant and higher medical malpractice costs overall.

The questicn of the extent of medical injuries caused by the negligence of health care providers which do not result in malpractice claims is still unanswered. Cne study, again ccmmissioned by the Secretary's Commission on Medical Malpractice, found that of 23,750 discharges from twc hospitals studied, 1,780 patients had received medical injuries during treatment, 517 of which were caused by the negligence of health care providers. The investigators fcund that only 31 malpractice claims would be filed during the year in which the study was made. Since there were cnly 12,600 claims asserted in 1970 throughout the nation, and over 30 million hospital admissions a year (according tc the National Center for Health Statistics),

it appears that malpractice claims are instituted in only a small fraction of cases where medical injuries through negligence have occurred.

Medical malpractice, and claims that result from alleged malpractice, create additional problems regarding the delivery of medical services. Physicians, because of their great concern for avoiding malpractice suits, frequently practice defensive medicine. Defensive medicine is defined as medical practices undertaken to avoid a malpractice claim or to provide protection in the event a claim is instituted. There is some evidence that defensive medicine is practiced, and that it results in higher health service costs and overutilization of scarce medical resources. The fear of charges of medical malpractice may also jeopardize the relationship between the physician and his patient, because each patient is viewed as a potential adversary in a medical malpractice lawsuit.

Perhaps the overriding concern of the health care providers in the United States, particularly the physicians, is the threat that they will be unable to purchase medical malpractice insurance because insurers will no longer be willing to offer it. The number of insurers who offer malpractice insurance appears to be decreasing. According to Gene Cudworth, Secretary of Hartford Insurance:

"The current malpractice situation represents probably the most serious problem faced by the insurance industry at any time in its history. Almost every carrier in the business is either restricting its business or getting out altogether.

"The number of companies involved in malpractice has always been small compared to the total number of insurance companies, but today there are only a half a dozen who handle the majority of malpractice business."

Insurers cite the major problems facing the insurer as: (1) the inability to predict with reasonable accuracy the number and size of claims that might arise from health service provider encounters with patients, (2) the relatively small number of insured providers, and the harmful impact a single very large award can have on reserves and rates, (3) inflation and its impact on future settlements, and (4) the concern that courts are increasingly making awards in the case of injuries whether or not negligence has been proven.

Although the claim is frequently made by providers of health services and by insurers that claims are seldom meritorious, available data do not support this contention. The Secretary's Medical Malpractice Commission asked insurers to examine cases they had settled to determine the percentages which were with and without merit. The insurers reported that 46% were meritorious. This was consistent with data on the percentage of cases resulting in payments to plaintiffs (45%).

Efforts to alleviate the medical malpractice problem frequently have been directed to methods of containing malpractice insurance premium increases and to assuring the continued availability of malpractice insurance for providers of health services.

Measures to contain malpractice insurance costs have been taken principally by insurers and State and local medical societies. Insurers frequently conduct educational programs designed to cut back on medical malpractice injuries and to make providers aware of what to do in the event a potential malpractice claim arises. Provider efforts to reduce malpractice

claims include the use of physician screening panels, which review potential malpractice claims with the physician involved, recommend that he attempt to settle or defend himself against the claim, and assist him in preparing for his defense. The insurer and the physicians' panels work together in assisting the physician. Another approach is medical-legal panels, comprised of both physicians and lawyers, with the latter considered to represent the interests of the claimants. Both the claimant and the defending physician are involved in this approach, with the stated purpose to settle as many cases as possible without court action. Another approach, increasingly used by health maintenance organizations, is binding arbitration. Experience with this approach is limited, but results have been encouraging. In Philadelphia and Allegheny Counties in Pennsylvania, the Courts by rule have initiated an arbitration requirement for all tort disputes involving less than $10,000, with the right of either party to demand a court trial, subject to certain economic penalties.

A demonstration project involving eight hospitals in southern California was initiated in July 1969 to determine the effectiveness of the arbitration of medical malpractice claims. Under the demonstration, persons admitted signed an agreement with the hospital to arbitrate any claims arising from actions by the hospital. The patient then had 30 days to rescind the agreement unilaterally. A control group of hospitals in the same area was also selected for purposes of comparison. A review of the findings for the period 1970-73 showed that the hospitals using arbitration had fewer claims, 310 to 350, a higher rate of settlement within the studied period, 50.7% to 40.66%, and faster settlement time. Within 35 months, the hospitals using arbitration had settled 96.7% of the claims, while the control hospitals had settled 80.0%. The analysis showed that during the period 1970-73, the settlement costs per claim increased 42.7% for the control group, from $3,494 to $4,986, while for the hospitals using arbitration the increase was 26.2%, from $2,562 to $3,244. Administrative and legal costs per claim were 50.0% less for hospitals using arbitration.

Increasingly, physicians have sponsored "group insurance" for physicians on a State or county basis. At least 25 States have medical-society-sponsored medical malpractice insurance programs. Hopefully, these programs will streamline insurance administration, improve physician education programs, and improve the physicians' ability to negotiate better insurance programs.

Although physicians understandably are concerned about the shrinkage in the number of insurers offering medical malpractice insurance, to date no groups of physicians have been denied coverage because they could not find a carrier. Where certain groups have faced severance of their coverage, the efforts of State governments, plus those of the physicians themselves, have resulted in obtaining coverage. In a case occurring in 1975 in Indianapolis, Indiana, it was necessary for the State insurance commissioner to intervene where the St. Paul Fire and Marine Insurance Company had withdrawn coverage from eight anesthesiologists. The insurance commissioner was successful in placing insurance with several insurers.

The medical malpractice crisis precipitated substantial State legislative activity. A review of State legislative activity relating to medical malpractice, conducted by the American Insurance Association, found that 35 States had enacted legislation in calendar year 1975 dealing specifically with the medical malpractice problem. The American Insurance Association also found as of June 16, 1976, that 42 States had enacted legislation to assure the availability of medical malpractice insurance, primarily by

requiring insurers offering certain lines of liability insurance in a State to offer medical malpractice insurance through joint underwriting associations. Other approaches include State-operated insurance pools and authority to physicians and hospitals to operate their own mutual insurance companies.

In 1969, the Subcommittee of Executive Reorganization (chaired by Senator Abraham Ribicoff) of the Senate Committee on Government Operations studied the problems of medical malpractice. The study report, entitled Medical Malpractice: The Patient Versus the Physician, included conclusions that medical malpractice was a serious and growing problem, that it was not being dealt with effectively, and that the Federal Government should have a role in dealing with the problem.

During the 92d Congress, the Subcommittee on Health (chaired by Senator Edward Kennedy) of the Senate Committee on Labor and Public Welfare held hearings on S. 3327, the Health Maintenance Organization and Resources Development Act of 1972, which provided physicians with the arbitration privilege as a quid pro quo for their participation in the bill's proposed quality assurance program.

At the request of former President Nixon, HEW Secretary Richardson convened a Medical Malpractice Commission, which began its work in September 1971. On Jan. 16, 1973, it issued a report containing recommendations covering 77 areas for improvement in dealing with the problems of medical malpractice; for example: the establishment of a nationwide data collection system, greater attention to injury prevention and quality controls in medical care delivery, application of the same legal doctrines to health professionals as those that apply to other forms of defendants, the use of imposed arbitration meeting certain specified criteria, encouragement of experimentation with contractual arbitration, and the cooperative effort of industry and health care providers in developing contingency plans in the event medical malpractice insurance becomes unavailable through normal market channels.

Policy considerations for the Congress include:

(1) What priority should be given to an investigation of the extent of medical injuries? What effect would findings of such an investigation have on the approach to legislation taken by Congress?

(2) How should efforts to improve the current situation regarding medical malpractice be linked to professional standards review organizations (PSROs)?

(3) Should arbitration in one or more of its several forms be the required mode for settling medical malpractice cases?

(4) Should the present tort liability system be improved to cause cases of alleged medical malpractice to be settled more quickly and more efficiently, e.g. by reducing legal expenses?

(5) Should injuries not currently compensable under the present tort liability system be included in the protection provided for patients or their legal representatives?

(6) To what extent and in what ways might Federal participation contribute to reductions in medical injuries and improvements in quality controls?

(7) How would the system be financed? To what extent might current malpractice costs be reallocated under new financing arrangements?

(8) Would Federal participation assist in reducing medical malpractice costs?

(9) Is the medical malpractice insurance industry sufficiently unstable and unpredictable to warrant Federal participation directly or in a reinsurance role?

LEGISLATION

H.R. 1305 (Holt)

Establishes a Commission on Medical Malpractice Awards. This bill was introduced on Jan. 14, 1975, and was referred to the Committee on the Judiciary.

H.R. 1378 (Rostenkowski)

Amends title XVIII of the Social Security Act to conform the timing of premium determinations thereunder with the automatic benefit increase provisions in title II of that Act, and provides for studies of malpractice insurance problems among physicians and hospitals. This bill was introduced on Jan. 14, 1975, and was referred jointly to the Committee on Ways and Means and the Committee on Science and Technology.

H.R. 3954 (Gonzales)

Amends title X of the U.S. Code to provide for an exclusive remedy against the United States in suits based upon medical malpractice on the part of active duty personnel, and for other purposes. This bill was introduced in the House on Feb. 27, 1975, and was reported by the Committee on Armed Services on June 27, 1975 (H. Rept. 94-333). It passed the House on July 21, 1975, and was subsequently referred to the Senate Armed Services Committee.

H.R. 6100 (Hastings)

Assists in the settlement of medical malpractice claims through a Federal program of reinsurance and through voluntary arbitration under State laws. The bill was introduced in the House on Apr. 17, 1975, and was referred to the Committee on Interstate and Foreign Commerce.

H.R. 6182, H.R. 6293 (Downey, Spellman, Hannaford/Cornell)

Authorizes the Secretary of Health, Education, and Welfare to establish a medical malpractice reinsurance program, and to conduct experiments and studies on medical malpractice. Both bills were introduced in April 1975, and were referred to the Committee on Interstate and Foreign Commerce.

H.R. 6766 (Hastings et al.)

Identical to H.R. 6100, the bill was introduced in the House on May 7, 1975, and was referred to the Committee on Interstate and Foreign Commerce.

H.R. 7008 (Spellman et al.)

National Medical Injury Compensation Insurance Act of 1975. Amends the Public Health Services Act to provide for a national program of medical injury compensation insurance. The bill was introduced on May 14, 1975, and was referred to the Committee on Interstate and Foreign Commerce.

S. 188 (Nelsen)

Authorizes the Secretary of Health, Education, and Welfare to establish a medical malpractice reinsurance program, and to conduct experiments and studies on medical malpractice. This bill was introduced on Jan. 16, 1975, and was referred to the Committee on Labor and Public Welfare. (Identical bills, H.R. 2804 (Downey) and H.R. 2884 (Gonzales), were introduced in the House on Feb. 5, 1975.)

S. 215 (Inouye, Kennedy)

Amends the Public Health Service Act to provide for a national program of medical injury compensation insurance. The bill was introduced on Jan. 17, 1975, and was referred to the Committee on Labor and Public Welfare.

S. 482 (Kennedy, Inouye)

Amends the Public Health Service Act to provide for a national program of medical insurance and arbitration of medical malpractice claims. The bill was introduced on Jan. 29, 1975, and was referred to the Committee on Labor and Public Welfare.

S. 1253 (Brock et al.)

Amends the Social Security Act to conform the timing of Medicare premium determinations with the timing of automatic increases in Old Age, Survivors, and Disability Insurance benefits. Directs the Office of Technology Assessment to engage the National Academy of Sciences to study and propose solutions for problems of medical malpractice insurance. Specifies that proposed solutions shall be related to the Medicare provisions of the Social Security Act. The bill was introduced on Mar. 20, and was referred to the Committee on Finance.

S. 1763 (Roth et al.)

Places specified limitations on the amount of the fee which may be charged by an attorney who brings a medical malpractice action before a Federal court. The bill was introduced on May 19, 1975, and was referred to the Committee on the Judiciary.

HEARINGS

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Multilith 75-3 ED

Solomon Garb MD
6401 W Colfax Ave
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Input DNA Research

College of Physicians & Surgeons of Columbia University | New York, N.Y. 10032

DEPARTMENT OF BIOCHEMISTRY

630 West 168th Street

June 14, 1976

Dr. Solomon Garb
6401 West Colfax Avenue
Lakewood, Colorado 80214

Dear Doctor Garb,

You asked me, in your letter of the 7th, to summarize briefly my views on the dangers of recombinant DNA research, as it is being contemplated now.

The genomes of all living beings, each acting as the signalling center for the entire biological future of the particular organism, are composed of DNA. These are enormously long chains which, in the form of coded messages, carry an array of signals for the production of enzymes, protein hormones, and in the last resort of all other materials making up the living cell. In addition, the DNA contains other regions that do not code directly for compounds, but act as spacers, starting and stopping signals, etc. The meaning of this arrangement and of the sequence in which the various biological messages are arrayed is little understood.

It is now possible to dissect a DNA molecule into fragments each of which may contain several genes or, rarely, even a single gene. These fragments can be incorporated, by highly technical expedients, into the DNA of a bacterial virus which then is transferred to a living culture of E.coli, the common intestinal bacterium. The E.coli cells thus infected, will now continue making the materials for which they have been coded by the recombinant DNA.

My objections have mainly to do with the choice of E.coli as the host of new forms of life. No containment will prevent the eventual spread of these potentially dangerous new organisms which will find their ecological niche in the human gut. If there exist genes responsible for malignancies, then the incorporation of pieces of human DNA into a bacterium that cohabitates with us may have disastrous effects. Even apart from this the creation of new forms of life is an irreversible process. A long period of discussion should precede this possibly very dangerous step.

Sincerely yours,

Erwin Chargaff
Professor Emeritus
of Biochemistry

EC:eh

FRIENDS OF THE EARTH 72 JANE STREET NEW YORK NEW YORK 10014

June 12, 1976

Dr. Solomon Garb
American Cancer Research Center
6401 W. Colfax Avenue
Lakewood, Colorado 80214

Dear Dr. Garb,

I am writing this letter to inform you of the most recent developments in the attempt to set up guidelines for recombinant DNA research (gene transplants).

Recent scientific technology has brought us to the brink of a new biologic era. Scientists are now technically equipped to pursue recombinant DNA research which can be employed in the manipulation and redesigning of human hereditable material, the genes. As you know, among many other hazards this type of experimentation creates the risk of producing and inadvertently dispersing new, uncontrollable organisms which may include carcinogens.

The controversy over this potentially hazardous type of genetic experimentation is gathering momentum within the scientific and public communities. It has become an issue of serious concern not only because of the moral and ethical questions that arise if scientists tamper with the heredity and evolution of their fellow-humans, but also because of the hazards of creating self-reproducing new organisms, "put together" by scientists which may prove to be uncontrollable, irreversible, and could contaminate large populations.

Unfortunately, since most of the scientists on the guidelines committee (Recombinant DNA Molecule Program Advisory Committee of the National Institutes of Health) are involved personally in this research, the decisions have resulted in setting up: 1.) inadequate laboratory safety requirements, 2.) the projected use of the human gut bacteria E. coli ("enfeebled") as a host organism, and 3.) assumptions that: a. the work will go ahead, b. we can "act now and learn later", c. the benefits outweigh the risks, d. every problem has a solution. This has occurred although eminent scientists from all over the United States have submitted statements, reports, letters and data calling for 1.) more stringent control measures, 2.) centralized P4 (strictest control level) laboratory facilities, 3.) the rejection of E. coli as host, and 4.) the postponement of the research.

The essential issues still remain to be discussed and decided publicly:

1. The biohazards of accidental release of uncontrollable new organisms.
2. The use E. coli (common to the human gut) as a host organism.
3. The implications of interference with evolution.
4. Reduction of diversity in the human gene pool.
5. The inherent fallibility of inspection, enforcement, and regulatory bodies.
6. The imposition of complex medical decisions on individuals and society.

The potentially irreversible and self-perpetuating hazards of recombinant DNA research would involve citizens alive today and those not yet born. It is therefore of utmost importance that the responsibility to protect the public take precedence over the "requirements" of science. We must prevent those who press so insistently for haste from forcing the premature expansion of this new technology.

The controversy should be opened up to the public and legislators so that an official moratorium on recombinant DNA research could be imposed pending further public investigation and subsequent public decisions. By acting now, before the intellectual and economic investment grows greater, we could help to avoid for this new technology the consequences of premature proliferation being suffered today by the nuclear energy industry, thirty years after its inception, in the form of insoluble problems (radioactive waste transport and disposal, sabotage, weapons proliferation, low-level radiation, etc.).

Because recombinant organisms once released into the environment from a laboratory are released irrevocably, we must assure in advance that the new technology of recombinant DNA research is based, not upon technical expectations and hopes, but upon replicated technical solutions.

I hope that this material is helpful in bringing the situation up to date. Director of the NIH, Donald Frederickson, plans to publish the guidelines on June 21, so time is of the essence.

Yours very truly,

Francine Robinson Simring

Francine Robinson Simring

Committee for Genetics

FRS:fh
enclosure

Recombinant DNA: Unknown Risks

Bernard D. Davis's letter (6 Aug., p. 442) makes interesting reading in a week in which 25 Legionnaires have died and more than 100 are still ill—some critically—of a disease of unknown ori-

gin, unusual virulence, and unprecedented epidemiology. If scientists do not conclude from this juxtaposition that it would be good to face up to ignorance in areas in which we have no experience, instead of engaging in facile speculation, I hope the public will.

I am not claiming that the mystery disease is a result of genetic manipulation, since obviously no one knows its cause. But I wish to point out that to pretend to know more than we do about causes and prevention of disease can only discredit science and scientists. (At this writing, infectious and toxic agents have in turn been ruled out as causes of "Legionnaire's Disease" and today's newspaper talks about Fort Detrick and possible unknown varieties of infectious agents.)

A further point: *if* a recombinant (and perhaps short-lived) coliform organism ever were to produce an outbreak of an epidemic, it might well be nearly impossible to identify or to culture as the cause in the presence of all the other, normal strains of *Escherichia coli* that grow in us.

Davis suggests that medical history shows such risks must be taken and implies that the high child mortality rate of a century ago was reduced through medical intervention. This is not true. Almost nine-tenths of the decline in the combined death rate from scarlet fever, whooping cough, diphtheria, and measles in children under age 15 occurred before the introduction of specific therapies or vaccinations; and similarly with tuberculosis, cholera, typhoid, and most other infectious diseases. The most probable reasons for these reductions were improvements in nutrition and public health measures—better housing, clean water, and so forth. The specific medical measures of the last three to four decades only clipped the tail off the asymptotic curve. This is not to underrate the importance of every life saved. Furthermore, those risks were taken to cure known diseases, not to create new ones.

RUTH HUBBARD

Biological Laboratories,
Harvard University,
Cambridge, Massachusetts 02138

Cambridge Council Bids Harvard Delay Its Gene Research

Special to The New York Times

CAMBRIDGE, Mass., July 7 —The Cambridge City Council voted tonight to establish a three-month "good faith" moratorium and study period for an experimental type of genetic research proposed by Harvard University, which is situated in this city.

It is believed to be the first time elected officials have attempted to regulate scientific work conducted by university laboratories.

The City Council, which itself has no power to police Harvard's scientific activities, could influence the city Health Commissioner to shut down laboratories performing research considered hazardous to the local populace.

Tonight's decision came after several weeks of public debate over Harvard's intent to use a new technique to study a genetic material, deoxyribonucleic acid (DNA). The technique, called recombinant DNA, involves isolating a tiny portion of animal or plant DNA and then inserting it, for analysis, into a common laboratory bacterium. The fusion that results yields a previously unstudied type of organism.

The technique has been a controversial topic within the scientific community since its discovery three years ago. The National Institutes of Health announced its guldelines for recombinant DNA research only two weeks ago.

The recombinant research requires a "P-3" safety precaution, the second-highest level within laboratories regulated by the Institute.

According to Prof. Matthew Meselson, chairman of the Harvard biochemistry and molecular biology department, who testified before the Council, Harvard would not only abide by the N.I.H. guidelines, but would also adhere to even stricter regulatory processes established by the university.

A number of local residents and scientists, including a Nobel-laureate biologist, George Wald, spoke in opposition to the proposed research. Michael Wolfson, a former laboratory technician at Cambridge's Massachusetts Institute of Technology, said he had quit his job after he observed "safety standards constantly violated, either by carelessness or accidents in the research lab."

The City Council members, also voted to establish a city review board, composed of scientists and lay persons, to investigate potentially dangerous university research.

New cancer virus prompts warning

WASHINGTON (UPI) — A Texas experiment that produced a cancer virus able to cross broad species barriers has prompted the National Cancer Institute to warn other laboratories to use caution when conducting such research.

The concern is this "pseudotype" virus might be able to infect humans if the virus is not properly contained in the laboratory.

SCIENTISTS FROM the Southwest Foundation in San Antonio reported Thursday that they created the virus by combining a harmless baboon virus with a mouse cancer virus which alone also is harmless. The product was a virus with a genetic information of the mouse agent with the coating of the baboon virus.

Dr. S.S. Kalter, director of microbiology and infectious diseases at Southwest, said the combined virus is able to cause tumors in dogs, baboons and chimpanzees as well as mice.

Dr. John B. Moloney, associate director in charge of virus research at the National Cancer Institute, which sponsored the Southwest work, said it has been found that new virus grows well in human cells in the test tube.

"Our concern is the biohazard nature of this thing," he said. "This pseudotype now has the ability to cross species barriers, broad species barriers. We are concerned that it could go into any species, including man."

Dr. Alfred Hellman, chief of the office of biological safety at the NCI, said institute officials were aware of the potential of the Southwest research and directed that the work be carried out in containment facilities.

When the results were reported to the NCI, Hellman said he sent a memo to other NCI contractors advising them of the hazard and warning them to use care when performing virus combination experiments.

THE GOAL OF such work is to better understand the role viruses have in human cancer, and to study interaction of such viruses. It has not yet been proven that viruses can cause cancer in humans, but many researchers believe that viruses are involved one way or another.

Kalter gave reporters a preview of his findings in San Antonio before flying to Cold Spring Harbor, N.Y. to formally report his work at a symposium there.

Kalter said containment procedures were tightened at Southwest when scientists discovered the combined virus could cause cancer in other animals.

"When the chips came down, that scared us," he said. "I think our initial feeling was more of fear than anything else. My gosh, if it's doing this to these animals, what's it going to do to us? And then if it happens to us, it could happen to anybody."

THE UNIVERSITY OF MICHIGAN
ANN ARBOR, MICHIGAN 48104

DEPARTMENT OF HUMANITIES
COLLEGE OF ENGINEERING
(313) 764-1420

June 18th 1976

Dear Dr Garb:

I write to express my support for a provision attached to the HEW appropriations for the coming year, specifying that no federal money will be used for research using recombinant DNA techniques until hearings have been held to evaluate the risks.

Recombinant DNA techniques constitute a revolutionary advance in our power to manipulate the environment, for by implanting bacteria and the cells of other organisms with the genes of totally unrelated organisms, the genetic heritage of millions of years of evolution may be rearranged, in short order. While it is possible that serious harm to human and other forms of life may follow from the use of recombinant DNA techniques, those molecular biologists who advocate this form of research are, in general, optimistic about the benefits to medical science and to industry which will follow. As a historian of science, I am reminded of a similar optimism thirty years ago with respect to the possibility of release of energy from matter through the use of nuclear fission techniques. It is well to remember that in the case of nuclear power, perception of the risks has grown, and perception of the benefits has correspondingly declined.

At present, the wider community of biologists is divided with respect to almost every crucial aspect of the hazards associated with recombinant DNA techniques: the precise degree and extent of harm should the novel microbes engineered by the techniques escape; the validity of the guidelines about to be released; the effectiveness of the use of enfeebled strains of host organisms in providing "biological containment."

In the light of this lack of consensus, I am troubled that input to decision-making in this area has come largely from actual or potential practitioners of the technique. While I do not question their good intentions, it is doubtful that scientists in the front ranks of research will judge the risks in ways that reflect the values of the general population. Furthermore, policy has apparently been tacitly assumed rather than explicitly formulated. It has been assumed that the traditional mode of scientific research, in which facilities proliferate and compete in exploiting a new and promising technique is appropriate here. But limits on expansion may be as critical a factor in averting harm as methods of containing the hybrid microbes. As numbers of laboratories and practitioners grow, the probability of accidents increases.

There is an urgent need for policy in this area and for democratically appointed bodies to develop it. Until such bodies are appointed and report, I believe that the only way to ensure the well-being of the wider population is to restrict research to a very small number of isolated, strictly supervised, high containment facilities. I therefore strongly support the proposed provision in the appropriations since it would have the effect of limiting expansion in this area. Only a far more cautious approach can adequately protect human life and the stability of the ecosystem.

Sincerely,
Susan Wright
Susan Wright
Assistant Professor

FRIENDS OF THE EARTH 72 JANE STREET • NEW YORK, NEW YORK 10014 • (212) 675-5911

FOR RELEASE: SEPTEMBER 22, 1976

MORATORIUM ON GENE TRANSPLANT RESEARCH DEMANDED BY ENVIRONMENTAL GROUP;

FOE CHARGES BETTER DISEASE PROTECTION FOR CATTLE THAN PEOPLE

Friends of the Earth, a national environmental organization, today attacked the National Institutes of Health guidelines on gene transplant (recombinant DNA) research as inadequate and unenforceable, and demanded an immediate official moratorium on all research, development, construction and funding in this area.

"Hazardous gene transplant research is proliferating on campuses and in populated areas across the country, funded by NIH and private industry," declared Francine Simring, chairman of FOE's Committee for Genetics. "The NIH research guidelines are purely voluntary, do not cover the private sector, and therefore are unenforceable."

Friends of the Earth further charged that NIH is involved in a conflict of interest because it is funding and promoting the very research the guidelines are set up to control.

Mrs. Simring pointed out that although scientists agree that one hundred per cent laboratory containment of potentially lethal organisms is unattainable, the release of the NIH guidelines has given the green light for most of the research.

Indicating that Plum Island, off our northeast coast, is the only facility in the country permitted to research hoof-and-mouth disease, an affliction of cattle, Mrs. Simring said, "Those who support these guidelines offer to us and to our children less protection than is accorded to American cattle raised for slaughter...It is simply unacceptable."

FOR FURTHER INFORMATION CALL:

Francine Simring 675-5911

DEPARTMENT OF MICROBIOLOGY AND MOLECULAR GENETICS
HARVARD MEDICAL SCHOOL
25 SHATTUCK STREET
BOSTON, MASSACHUSETTS 02115

July 15, 1976

Dr. Solomon Garb
6401 W. Colfax Ave.
Lakewood, Co 80214

Dear Dr. Garb,

I support your request for Congressional hearings on recombinant DNA research.

Sincerely,

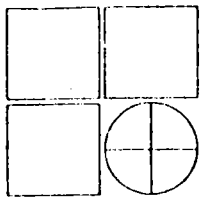
Jon Beckwith
Professor of
Microbiology and
Molecular Genetics

JB/am

SIDNEY FARBER
CANCER CENTER

44 BINNEY STREET
BOSTON
MASSACHUSETTS 02115
617-732-3100

JIMMY FUND





HARVARD
MEDICAL SCHOOL

June 14, 1976

Dr. Donald S. Frederickson
Director
National Institutes of Health
Bethesda, Maryland 20014

Dear Dr. Frederickson:

A group of us who work at the Sidney Farber Cancer Institute are concerned about the possibility that experiments involving recombinant DNA molecules will be performed in the research laboratories in our hospital. Aside from the many serious questions which have been raised about the potential hazards involved in this research, we see at least two potential hazards specific to doing these experiments in a cancer hospital:

(1) The organism which will serve as the host for many recombinant DNA's is Escherichia coli. E. coli is a common cause of hospital infections and is a leading cause of septicemia. For every 1000 patients who enter Boston City Hospital, 1.75 die from E. coli septicemia. (Journal of Infectious Diseases, 132: 316 (1975))

(2) A large proportion of the patients in cancer hospitals are receiving either immunosuppressive drugs or antibiotics which destroy the normal intestinal flora. A newly created, highly virulent form of E. coli could wreak havoc in such a patient population.

As you are aware, according to the Wedum report, even the most rigorous containment facilities cannot guarantee absolute containment of microorganisms. Since most hospitals are not equipped with rigorous containment facilities, it is highly probable that new, possibly dangerous forms of microorganisms will be spread around hospitals, the major vector being the laboratory personnel who are doing the experiments, the maintenance workers, and the housekeeping staff.

No one can predict what the consequences of this research will be. We do not believe, however, that the patients in a hospital should be used as "guinea pigs" in determining whether the putative hazards are

real hazards. We would like to urge that the forthcoming N.I.H. guidelines on recombinant DNA research prohibit such research from being performed in a hospital.

Sincerely yours,

Robert D. Dubrow
Research Associate

Rolf F. Kletzien
Research Associate

Michael R. Miller
Research Associate

ds

Marine Biological Laboratory
WOODS HOLE, MASSACHUSETTS 02543

July 10, 1976

Dr. Solomon Garb
6401 West Colfax Avenue
Lakewood, Colorado 80214

Dear Dr. Garb:

I understand that you, like I, are worried about the possible risks engendered by the new technology that permits the transfer of genes from one kind of organism to another by generating what are called recombinant DNA molecules. I am troubled by many aspects of this work, but what worries me most is as follows:

1. Most biologists believe that living organisms have come into some sort of equilibrium with their environment (including other organisms) over time spans of many millions of years. We do not know how new kinds of organisms arise in nature, but we can be sure that this also is a very slow process. When changes are sudden -- as environmental changes have been sometimes -- it can have dire consequences for organisms. This new technology introduces sudden changes into organisms and we cannot predict their effects either on the organisms themselves or on their environments, because these new organisms will have to find new ways and places to live. It could therefore produce sudden major perturbations in the many and varied interactions whose magnitudes and effects we cannot predict and therefore cannot prepare for.

2. The favorite host organism into which foreign genes are implanted is the common colon bacillus, E. coli. Millions of coli bacteria live in all of us as well as in our domestic animals, in insects, water, soil -- indeed everywhere around us. Occasionally and for reasons we do not yet understand E. coli causes diseases such as diarrhea, urinary tract or bladder or kidney infections, prostate infections and others. To tamper with the genes of E. coli seems madness, because if a dangerous strain arose, it would be dispersed far and wide before we would even know that it existed, for it takes only 20 minutes for one E. coli to become two.

3. No adequate precautions can be taken to keep this organism from getting out of the laboratory, because the main vector will be the people who work with it.

Therefore, if this work is done (and I would like to see a much wider and more thorough discussion of whether this should be),

1. it should be done at one or very few central facilities away from centers of population, to which access is restricted to the people who work there, so that the whole operation could be closely monitored until we know a great deal more about the potential hazards.

2. Every effort should be made in the mean time to find an organism or a cell line that does not get about as freely in us and our environment as does E. coli.

Sincerely yours,

Ruth Hubbard

Ruth Hubbard
Professor of Biology
Harvard University
Cambridge, Massachusetts 02138

• INDEPENDENT PHI BETA KAPPA ENVIRONMENTAL STUDY GROUP

Elise Jerard - *Chairman* 115 Central Park West, N.Y., N.Y. 10023

• CITIZENS RIGHTS COMMITTEE

~~32 Charles Street, Hicksville, L.I., N.Y. 11801~~

July 27, 1976

Dr. Solomon Garb
Citizens Committee for the
Conquest of Cancer
6401 West Calfax Street
Lakewood, Colorado 80214

Dear Dr. Garb:

I write as chairman of the Independent Phi Beta Kappa Environmental Study Group, a research society of 1001 professionals. My work for the doctorate was done in biological sciences. I am also a member of the Scientists Advisory Committee of the Environmental Defense Fund and of the Natural Resources Defense Council as well as a Fellow of the Scientists Institute for Public Information.

I am deeply interested in joining the efforts of those who are fighting environmental cancer. Dr. Wilhelm Hueper, who was Chief of the Environmental Cancer Section of the National Cancer Institute and the internationally honored oncologist, was a close associate of mine for many years.

We are, of course, opposed to the proliferation of recombinant DNA research along the present lines and with guidelines wholly inadequate to the protection of the public which is already multiply exposed to environmental carcinogens.

My friend, Dr. George Wald and his wife, biologist Dr. Ruth Hubbard, have been represented in last week's issue of Science as arousing the Mayor of Cambridge, Massachusetts, in opposition against the Harvard program, but in fact the Mayor appealed to Dr. Wald, who was extremely busy preparing his recent experiments for publication, to enter this battle for human protection.

In our opinion, the National Institutes of Health are not equipped to set forth guidelines for any such unprecedented and extremely hazardous undertaking as the genetic engineering which has been pioneered by the Harvard scientists. It might be of some use to the formation of a committee of qualified and independent scientists, together with generalists who have enough intelligence and scientific background to see the involved basics in human perspective.

With the welter of risks haphazardly accumulated we can no longer afford to consider the advancement of science as overriding the interests of the social community. Where scientists differ sharply it is obvious that some deeper ruling principle must be invoked. Know-how must yield to know-why and know-why-not.

This is the position also of the Citizens Rights Committee, with participants in 33 States, of which I am chairman.

I should be interested in learing more about Citizens Committee for the Conquest of Cancer.

Cordially,

Elise Jerard (pm)

EJ/pm

Elise Jerard, Ph.D.

6/14/76

NATIONAL JEWISH HOSPITAL AND RESEARCH CENTER
3800 EAST COLFAX AVENUE ■ DENVER, COLORADO 80206 ■ TELEPHONE 303/322-1881

Soloman Garb, M.D.
6401 W. Colfax Ave.
Lakewood, CO 80214

Dear Dr. Garb:

I am writing to you out of concern about the potential dangers of gene manipulation. Recent events have convinced me that a biological disaster is almost inevitable using the National Institutes of Health Guidelines to allow gene-splicing research to begin.

Biologists are new capable of creating new organisms that have never before existed in nature using new laboratory techniques that allow the splicing together of genes from diverse species. These novel arrangements of genetic material bypass the evolutionary process and the results are not predictable. The host for the hybrid genes is the standard laboratory bacterium, Escherichia coli, which is also a major inhabitant of the human gut and throat. It readily becomes airborne in a laboratory.

Three and a half years ago Dr. Paul Berg created a synthetic gene containing a monkey cancer virus and human gut E. coli genes. Dr. Berg and 10 other molecular biologists, including 2 Nobel Laureates, asked for a moratorium on this research stating that such synthetic organisms "might be more easily disseminated to bacterial populations in humans and...possibly increase the incidence of cancer or other diseases." Irwin Chargraff of Columbia University, who recently received the National Medal of Science from President Ford for his work on the structure of DNA, has written in The Sciences that "the spreading of experimental cancer may be confidently expected."

The National Institutes of Health guidelines which allow gene manipulation to continue will be released later this month. These guidelines have been devised almost solely by practitioners of gene manipulation, clearly a vested interest group. Despite repeated requests from within and without the NIH Guidelines Committee for public participation, NIH has declined to respond. Dr. Jonathan King of MIT saw the NIH Committee functioning "to protect geneticists, not the public."

There has been no direct input from the general public in deciding whether and how to proceed with gene manipulation. Informed consent by the public must be given before research in gene manipulation continues further as the public, not the biologists, have the most to gain as well as the most to lose by gene mixing.

I recently attended the Miles Symposium on Genetic Engineering and can tell you that a large number of academic and industrial laboratories throughout the world are currently actively pursuing gene manipulation without what I and many others would consider proper caution.

We are at the dawn of synthetic biology on our only habitable planet. What we create will be irreversible as we are dealing with replicating organisms, not mere chemicals. If human patterns are any guide, it will take a major biological disaster to arouse effective concern. I hope that you will be able to help intervene through asking for congressional public hearings before such a disaster occurs.

Sincerely,

Stephen L. Wiesenfeld, M.D.

Citizens' Committee for the Conquest of Cancer

870 United Nations Plaza, New York, N.Y. 10017 212-421-9011

Co-Founder
SIDNEY FARBER, M.D. (1903-1973)

Co-Chairpersons
EMERSON FOOTE
SOLOMON GARB, M.D.
KAY MANSOLILL

September 17, 1976

Senator Edward Kennedy
Subcommittee on Health
U.S. Senate
Washington, D.C. 20510

Dear Senator Kennedy,

I respectfully request that this letter be made part of the record of the Hearings on recombinant DNA research. This research is the most dangerous program ever undertaken by any person or group, and should be evaluated by the entire nation through the Congress, not by a small group of scientists with vested interests.

1. The key issue is not how recombinant DNA research should be done, but whether it should be done. A related issue is who should make the decision. Dr. Frederickson has assumed that he has the right and the authority to make the decision after seeking the advice of people whom he chooses to listen to. Many of us feel that he does not have any such right morally, and we would like clarification of his legal right to do this.

2. A glaring example of the inadequacy of the NIH guidelines is the section on inspection. NIH makes no realistic provision at all for outside inspection, but leaves all inspection for compliance with the guidelines in the hands of a committee at each university involved. To anyone, who like myself, has served on university committees for twenty years, it is ridiculous to expect any effective policing from such committees.

In other areas, concerned with public health and safety, there are legal requirements for inspection by government inspectors. These areas include restaurants, elevators, pharmaceutical manufacturers, meat packing companies, and even barber shops. Would we turn over inspection of a restaurant to a committee of the restaurant's employees? Would we turn over inspection of a meat packing firm to a committee of that firms employees? Hardly. Why then is Dr. Frederickson ready to turn over inspection of recombinant DNA research labs to colleagues in the same institution? Does he regard scientists as inherently more reliable than restaurant workers, meat packers, elevator operators, or barbers?

The significance of this omission of adequate and meaningful inspection extends beyond the question of inspection. It shows clearly that despite the voluminous and detailed published guidelines by NIH, there has not been the

kind of mature, deliberate and unbiased consideration that a topic of this seriousness deserves. It also shows clearly that Dr. Frederickson and his advisors are not competent to make decisions of this nature. Thus, even the addition of a requirement for adequate outside inspection would not make the NIH position acceptable.

3. The hearings held by NIH were not as unbiased as Dr. Frederickson would have us believe. Those who testified in favor of recombinant DNA research had their travel expenses paid by their grants or their universities. Those who wished to testify against it would have been required to pay the travel expenses from their own pockets and couldn't afford to go. Therefore, the hearings were a distortion of true scientific sentiment.

4. Containment facilities are never absolute. They can reduce contamination but not eliminate it. The best containment facilities in the world, at Fort Detrich, failed several times, with infections and deaths resulting. Luckily, the failure did not involve organisms, like E. Coli that can replicate rapidly outside cells. Unfortunately, the recombinant DNA studies will involve E. Coli.

5. Dr. Frederickson claims that only a weakened strain of E. Coli would be used, and that the risk of its replication outside the laboratory is insignificant. We disagree. Dr. Frederickson may be 99.999% right. However, if one drop of culture containing the organisms splashes and gets outside the containment facility, some 100,000,000 bacteria may be involved. If 99.999% of them cannot survive, that still leaves 1,000 that can survive and replicate. If they contain viral genes, they could cause a deadly epidemic.

6. Some proponents of recombinant DNA research argue that genetic recombination takes place every day in nature and that doing it in the laboratory is not significantly more hazardous. That argument is a half-truth and completely misleading. The genetic recombination that takes place in nature is between closely related organisms, usually of the same species. The proposed laboratory studies, however, involve organisms of grossly dissimilar types. In the laboratory, scientists have created frog eggs that produce bee venom. When did that happen in nature?

7. Proponents of recombinant DNA research have contended that this research could lead to information that might unravel the mystery of cancer. These proponents have seldom if ever, had any responsibility for the medical care of patients with cancer. My personal opinion, based on years of cancer research, including responsibility for cancer patients, is that recombinant DNA research is far more likely to cause a cancer epidemic than it is to lead to clinically useful information about cancer.

In support of this opinion, I enclose a newspaper clipping dated May 28, 1976. Please note that scientists combined a harmless baboon virus with a mouse cancer virus that by itself is also harmless to other species. The hybrid virus, however, causes cancer in a wide variety of species, probably including man. Fortunately, it has not yet escaped from the laboratory.

8. I will take one example from the published NIH guidelines to show that despite their length and apparent detail, they are essentially worthless. It reveals that Dr. Frederickson either does not grasp the degree of hazard involved or is not telling us about it.

In explaining guideline VI, L on Page 27909 of the Federal Register, Dr. Frederickson discusses the concern of many commentators over the use of SV40 virus for recombinant studies. It is noteworthy that most of these commentators are generally in favor of recombinant DNA research and can be considered members of Dr. Frederickson's "team". On this particular point, however, even they felt that the risks were too great, and that recombinant DNA research using SV40 should be banned.

Dr. Frederickson overruled them and is permitting research with SV40 to proceed. His discussion and reasoning is based on his statement that there is no evidence that SV40, a monkey virus, can cause cancer in humans. That may be true of unchanged SV40. However, an altered SV40 could cause a disastrous cancer epidemic. Again, let us look at the enclosed May 28 newspaper clipping. A baboon virus harmless to man, and a mouse virus harmless to man, when combined, produce a virus that grows well in human cells, and that "scared" the scientists working with it. It is noteworthy that this newspaper report appeared before publication of the NIH guidelines. It is difficult to believe that Dr. Frederickson was unaware of it. How then can he claim that the lack of evidence of human harm from unaltered SV40 is reason to permit its continued use in experiments that alter it? This is especially disturbing since Dr. Frederickson's own allies and supporters have warned about Sv40.

I doubt if the Congress would allow a committee from the Pentagon to declare war, or allow a committee from the State Department to decide on foreign policy. Recombinant DNA research is a greater hazard than war, or errors in foreign policy. Therefore, decisions in this area should not be left to committees of scientists, loaded with those having vested interests in this area. Congress should investigate the area thoroughly, hearing from many experts including physicians, veterinarians, plant pathologists, disaster control experts, public health officials, nurses, and others who have experience in dealing with infectious disease. Also, groups concerned with the environment and natures' balance, such as Friends of the Earth, ought to be heard. Until such hearings are held, and until Congress decides on whether recombinant DNA research should proceed, all such research, however funded, should be stopped completely. Anything less might destroy mankind, and perhaps all higher forms of life on this planet.

Yours truly,

Solomon Garb

Solomon Garb, M.D.

gr
enclosure

The Sunday Bulletin

Section

FOC

WA SEPTEMBER

HERB DENENBERG P. 2
DEAR ABBY P. 4
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BOOKS P. 6-7
ART P. 8

Herb Denenberg, member of the National Academy of Science, former Pennsylvania Insurance Commissioner and Public Utility Commissioner, former Loman Professor at the Wharton School of the University of Pennsylvania, former Professor of Law at Temple University, writes this syndicated column for the Philadelphia Sunday Bulletin (circulation about 640,000).

World's Scientists Now Produce Ultimate in Pollution



Herb Denenberg says . . .

WE'RE A LONG WAY down the path of killing and contaminating our environment. But now we have a new pollutant to end all pollutants.

Our latest growth industry is the manufacturing of new viruses, new bacteria, and new diseases.

Scientists all over the world are now producing the ultimate in pollution — new biological organisms that multiply and that can cause and spread disease to the last generation.

The public is almost totally unaware of the hazard, although it represents the most serious threat to our environment in history.

As usual, our scientific-medical-government establishment has made critical decisions on this kind of research that can wipe us out, without public consultation or public understanding.

We pour billions of our tax dollars into medical research that is supposed to save and prolong life. But we get incredibly dangerous biological pollution, according to Dr. Jonathan King, professor of biochemistry at MIT.

Here's an example. This year a laboratory in Texas combined a harmless baboon virus with a cancer virus from a mouse.

Presto. It created a brand-new virus capable of infecting dogs, baboons, mice, chimpanzees and possibly man.

The new viruses may stay where they're supposed to stay, if we're always lucky and always cautious. But they may escape from their confines and go on to spread infection forever.

A spokesman for the National Cancer Institute admitted to me that in their own labs there has been accidental exposure to laboratory viruses four of five times during the last year alone.

HOW COULD THAT happen? He said that a scientist may be injecting a mouse with a virus, miss the mouse, and get himself.

Dr. Stephen L. Wiesenfeld of the National Jewish Hospital told me there have been hundreds of reports of such laboratory acquired infections, and he says there is no way to guarantee safety.

Science can give us many miracles. But one we should not expect is for it to keep laboratory manufactured organisms confined to their assigned places.

Thus, a new disease may be born. And that new disease may be both undetectable and untreatable by conventional methods. It may strike a year from now or 20 years from now.

Even deadly nuclear wastes can be detected, measured, and monitored. There is no way to do that for laboratory produced microorganisms that escape.

And as Dr. Richard Goldstein of Harvard Medical School told me once a laboratory microorganism escapes, "we can't go out and chase it with a butterfly net."

Warnings such as these are coming from distinguished scientists all over the world. Dr. Solomon Garb, Director of the American Cancer Research Center put it this way:

"The technology now exists to take a virus or a bacteria and make virtually any mutation you want to make; add or subtract any characteristics you choose; engineer an entirely new form that would not show up in any of the known testing procedures aimed at disease detection."

Dr. Garb was referring to the newest technology of disease building which is called by various names — genetic manipulation, gene transplantation or recombinant DNA work.

NOW IN ADDITION to creating hybrid viruses, such as the baboon-mouse combination I've described above, scientists can actually transplant genes from one organism to another and come up with a new creation. They can transplant one gene or 10,000 of them according to Dr. Goldstein and the only certainty is that the results are unpredictable.

This capability of producing hybrid organisms sounds like a hybrid itself — a cross between science fiction and the Book of Genesis in the Bible.

Our scientists are playing God, but without taking the precautions He undoubtedly took when He engaged in the act of creation.

Existing controls are totally inadequate and they are only applicable to government financed research. They don't even involve inspection.

A potentially catastrophic situation is likely to get worse, as this kind of scientific God-playing can even be carried on in a high school lab.

There is need for public involvement and political airing of this whole research process.

Where will it all lead? Maybe we're already getting the answer. Some of the medical experts, quoted by name above, say this kind of scientific God-playing, not only could spawn a mysterious Legionnaires disease, but might in fact be the culprit.

We have a lot to learn about both the technique and price of environmental pollution.