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HEALTH SERVICES EXTENSION ACT OF 1978

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HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH

OF THE

COMMITTEE ON HUMAN RESOURCES UNITED STATES SENATE

NINETY-FIFTH CONGRESS

SECOND SESSION

ON

S. 2474

TO AMEND THE PUBLIC HEALTH SERVICE ACT TO EXTEND THROUGH THE FISCAL YEAR ENDING SEPTEMBER 30, 1983, THE ASSISTANCE PROGRAM FOR COMMUNITY HEALTH CENTERS; MIGRANT HEALTH SERVICES; TO EXTEND THROUGH THE FISCAL YEAR ENDING SEPTEMBER 30, 1981; HEMOPHILIA; HOME HEALTH SERVICES; TO EXTEND THROUGH THE FISCAL YEAR ENDING SEPTEMBER 30, 1979, THE ASSISTANCE PROGRAMS FOR COMPREHENSIVE PUBLIC HEALTH SERVICES; HYPERTENSION PROGRAMS; DISEASE CONTROL PROGRAMS; VENEREAL DISEASE PROGRAMS; GENETIC DISEASES PROGRAMS; AND LEAD-BASED PAINT PROGRAMS, AND FOR OTHER PURPOSES

FEBRUARY 9 AND MARCH 1, 1978

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HEALTH SERVICES EXTENSION ACT OF 1978

THURSDAY, FEBRUARY 9, 1978

U.S. SENATE,
SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH
OF THE COMMITTEE ON HUMAN RESOURCES,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10:15 a.m. in room 6226, Dirksen Senate Office Building, Senator William D. Hathaway presiding pro tempore.

Present: Senators Hathaway and Javits.

Senator HATHAWAY. The subcommittee will come to order. This morning, we are holding hearings on the Health Services Extension Act. Senator Kennedy is unable to be here this morning, and his statement will be included in the record at this point.

[The opening statement of Senator Kennedy follows:]

OPENING STATEMENT OF SENATOR EDWARD M. KENNEDY

Senator KENNEDY. I am pleased to open the first of 2 days of hearings on S. 2474, the "Health Services Extension Act of 1978," which I introduced last week together with Senators Schweiker, Javits, Williams, Pell, and Hathaway. These amendments extend various health services grants programs administered in the Public Health Service.

Last November, our subcommittee had the opportunity to review many of these programs in operation throughout the country. Senators Javits, Schweiker, and I were in Atlanta to review the work of the Center for Disease Control. We were privileged to tour their modern facilities and laboratories, to talk personally with the dedicated staff of the Center, and to learn firsthand about the vital and important work that the Center performs in disease control and preventive health services.

The legislation we will be considering this morning would extend currently expiring authority for many of these CDC programs, including initiatives in immunization, rodent control, venereal disease, lead-based paint, hypertension, and others. Our legislation proposes only 1-year extensions of these programs and of the program under 314(d) for comprehensive public health services. This is not because we are unhappy with the thrust of these initiatives, or with their administration, but because we recognize that as a group they comprise a significant portion of the Federal Government's investment in services directed at prevention of disease. Disease prevention is one of my paramount concerns in health, and later this year I

intend to introduce comprehensive proposals aimed at expanding the Federal Government's commitment to preventing illness. In order to have the flexibility to integrate statutory authority in this important area, we are reserving the option of reviewing these expiring authorities later in the context of a broad prevention effort.

In our subcommittee's travels last November, we also visited community health centers in Miami, Fla., Houston, Tex., and Los Angeles, Calif. I was impressed with the modern new facilities and equipment in these centers, and with the very dedicated and hard-working people who staff the centers. I had the chance to talk with many of the people who use the centers. Without exception these people felt that in the absence of this grant program, they would not have access to the kind of care which they have a right to expect in this Nation of ours. They were satisfied with the services they received. They felt their participation in the governance of the centers helped to make the services more responsive to their needs and desires. And they expressed to me their feelings that the support for the centers must continue and be expanded.

I also visited a migrant health center and a migrant camp in Homestead, Fla. The contrast between the modern facilities available through the community health center in Miami, and the old, crowded, ill-equipped health facility used by the migrants, was startling. The migrants told me they could use the modern facility in Miami, but preferred the migrant health center which was closer to their camp, and where the staff seemed more sensitive to their special needs and problems. The migrants made it very clear to me that they felt they needed the special migrant health program, and would oppose any consolidation of that program with the broader community health center program. They also pleaded for increased funding of the migrant health program and continued requirements for migrant control of the projects.

The legislation we are considering today supports the findings of the subcommittee from its field hearings and visits, and we will hear testimony this morning on the community and migrant health center programs.

These programs have demonstrated over the last 8 years that they deliver comprehensive health services at a cost less than or comparable to services provided through other health care delivery systems. Moreover, they have been effective in reducing use of hard-pressed emergency room facilities, they have provided preventive services to an extent which exceeds the traditional health care delivery systems, and they have made health services available to urban and rural communities previously without health professionals or health care facilities.

The bill before the subcommittee today reauthorizes both of these programs for a 5-year period. It is an expression of the view of this subcommittee that federally supported health centers have reached the point where their very existence no longer has to be reexamined every year. For example, since 1974—

—Physician productivity in health centers has increased by 30 percent;

—The cost per patient visit has declined by 5 percent—at a time when similar costs in other health care delivery settings have increased at a rate of 30 percent;

—Administrative costs incurred by health centers have declined by 15 percent.

S. 2474 authorizes $364 million for Community Health Centers for fiscal year 1979, including $34 million for the conversion of outpatient departments in urban hospitals into primary health care centers. In each of the four succeeding fiscal years, funding for Community Health Centers will increase by 10 percent.

The sum of $50 million is authorized for Migrant Health Centers for fiscal year 1979, including a doubling of the funding available for hospitalization. These amounts will also increase by 10 percent in each of the 4 succeeding fiscal years.

We will also hear testimony today on increasing the authorization for the National Health Service Corps, as requested in the President's budget. I have been a strong proponent of the National Health Service Corps since it was created in 1970. The Corps has expanded greatly from 20 filed assignees in 1971 to a projected 1,725 in 1979.

The Corps, however, has several important issues that they must study closely in the coming months. Is the Corps a manpower program or a service delivery program? Is the Corps meeting the needs of the populations it is legislated to serve? What are the best projections available for the Corps' future? All these questions and other related issues are ones that S. 2474 is asking the Department and the National Advisory Council to the National Health Service Corps to address in a special report to this committee.

And finally, this morning we will hear testimony on the small but important program which provides funds for treatment centers for hemophilia victims and also supports blood separation centers. The activities in this program are proposed by S. 2474 to be extended for 3 years with some increase in authorization levels. We hope to hear this morning of the needs these programs are meeting and how effectively the needs are being met.

[A copy of the bill S. 2474 follows:]

95TH CONGRESS
2D SESSION

S. 2474

IN THE SENATE OF THE UNITED STATES

FEBRUARY 1 (legislative day, JANUARY 30), 1978

Mr. KENNEDY (for himself, Mr. SCHWEIKER, Mr. WILLIAMS, Mr. JAVITS, Mr. PELL, and Mr. HATHAWAY) introduced the following bill; which was read twice and referred to the Committee on Human Resources

A BILL

To amend the Public Health Service Act to extend through the fiscal year ending September 30, 1983, the assistance program for community health centers; migrant health services; to extend through the fiscal year ending September 30, 1981; hemophilia; home health services; to extend through the fiscal year ending September 30, 1979, the assistance programs for comprehensive public health services; hypertension programs; disease control programs; venereal disease programs; genetic diseases programs; and lead-based paint programs, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SHORT TITLE

SEC. 101. (a) This Act may be cited as the "Health Services Extension Act of 1978".

(b) Except as otherwise specifically provided, whenever in this title an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Public Health Service Act.

COMPREHENSIVE PUBLIC HEALTH SERVICES

SEC. 102. (a) Section 314(d)(7)(A) (relating to authorizations for formula grants to States for comprehensive public health services is amended by striking out "and" after "1977,", and inserting before the period at the end of the sentence thereof the following: ", $107,000,000 for the fiscal year ending September 30, 1979".

(b) Title III is amended by adding at the end thereof the following new section (relating to authorizations for formula grants to States for hypertension programs):

"GRANTS FOR HYPERTENSION PROGRAMS

"SEC. 315. (a)(1) The Secretary may make grants to States (which have submitted and had approved State plans in accordance with regulations and guidelines issued by the Secretary) for the purpose of establishing and maintaining programs for the screening, detection, diagnosis, prevention, and referral for treatment of hypertension.

"(2) The Secretary shall, in accordance with such regulations as he may prescribe, allot the sums appropriated

under subsection (4), among the States on the basis of the population and financial need of the respective States.

"(3) Nothing in this section shall be construed to prohibit the use of funds for hypertension programs which may be authorized and made available under any other provision of law.

"(4) To carry out the purposes of this section, there are authorized to be appropriated $15,000,000 for the fiscal year ending September 30, 1979.".

DISEASE CONTROL PROGRAMS

SEC. 103. (a) Section 317(g)(1)(A) (relating to authorizations for grants to States for disease control programs to immunize children against immunizable diseases) is amended (1) by striking out "and" after "1977,", and (2) by striking out "for fiscal year 1978" and inserting in lieu thereof the following: "for the fiscal year ending September 30, 1978, and $35,000,000 for the fiscal year ending September 30, 1979".

(b) Section 317(g)(1)(B) (relating to authorizations for grants to States for disease control programs for diseases borne by rodents) is amended (1) by striking out "and" after "1977,", and (2) by striking out "for fiscal year 1978" and inserting in lieu thereof the following: "for the fiscal

year ending September 30, 1978, and $14,500,000 for the fiscal year ending September 30, 1979".

(c) Section 317(g)(1)(C) (relating to authorizations for grants to States for disease control programs, and other programs with authorizations under subparagraphs (A) and (B)) is amended (1) by striking out "and" after "1977,", and (2) by striking out "for fiscal year 1978" and inserting in lieu thereof the following: "for the fiscal year ending September 30, 1978, and $5,500,000 for the fiscal year ending September 30, 1979".

PREVENTION AND CONTROL OF VENEREAL DISEASE

SEC. 104. (a) Section 318(b)(2) (relating to authorizations for grants for projects for the conduct of research, demonstration, education, and training programs for the prevention and control of veneral disease) is amended (1) by striking out "and" after "1977", and (2) by striking out "for fiscal year 1978" and inserting in lieu thereof the following: "for the fiscal year ending September 30, 1978, and $8,000,000 for the fiscal year ending September 30, 1979".

(b) Section 318(c)(2) (relating to authorizations for project grants to State programs for prevention and control of venereal disease project grants) is amended (1) by striking out "and" after "1977", and (2) by striking out "for fiscal year 1978" and inserting in lieu thereof the following:

"for the fiscal year ending September 30, 1978, and $43,500,000 for the fiscal year ending September 30, 1979".

MIGRANT HEALTH

SEC. 105. (a) Section 319(h)(1) (relating to authorization for project grants for planning and development of migrant health centers) is amended by striking out "and" after "1977," and inserting before the period at the end of the first sentence the following: ", $4,000,000 for the fiscal year ending September 30, 1979, $4,000,000 for the fiscal year ending September 30, 1980, $4,000,000 for the fiscal year ending September 30, 1981, $4,000,000 for the fiscal year ending September 30, 1982, and $4,000,000 for the fiscal year ending September 30, 1983".

(b)(1) Section 319(h)(2) (relating to authorizations for operation of migrant health centers) is amended by striking out "and" after "1977,", and inserting before the period at the end of the first sentence thereof the following: ", $40,000,000 for the fiscal year ending September 30, 1979, $44,000,000 for the fiscal year ending September 30, 1980, $48,400,000 for the fiscal year ending September 30, 1981, $53,240,000 for the fiscal year ending September 30, 1982, and $58,564,000 for the fiscal year ending September 30, 1983".

(2) The third sentence of section 319(h)(2) is amended by striking out "and" after "1977,", and insert-

ing before the period at the end thereof the following: ", the fiscal year ending September 30, 1979, the fiscal year ending September 30, 1980, the fiscal year ending September 30, 1981, the fiscal year ending September 30, 1982, and the fiscal year ending September 30, 1983".

(c) Section 319(h)(3) (relating to authorizations for inpatient and outpatient hospital services) is amended by striking out "and" after "1977,", and inserting before the period at the end of the sentence thereof the following: ", $6,000,000 for the fiscal year ending September 30, 1979, $6,600,000 for the fiscal year ending September 30, 1980, $7,260,000 for the fiscal year ending September 30, 1981, $7,986,000 for the fiscal year ending September 30, 1982, and $8,784,600 for the fiscal year ending September 30, 1983".

COMMUNITY HEALTH CENTERS

SEC. 106. (a) Section 330(b) is amended by adding at the end thereof the following new paragraphs:

"(4) The term 'community hospital' means either a public general hospital owned and operated by a State, county, or local unit of government located in an urban area and primarily serving a population designated by the Secretary as having a shortage of personal health services, or a private, nonprofit community hospital located in an urban

area and primarily serving a population designated by the Secretary as having a shortage of personal health services.

"(5) The term 'primary care center' means a unit of a community hospital which—

"(A) delivers primary health services to a catchment area (as determined by the hospital and approved by the Secretary) through a group of health professionals composed of primary care physicians and allied health personnel; and

"(B) provides both (1) referral to emergency medical services and (ii) access to patient medical records on a twenty-four hours a day, seven days a week basis; and

"(C) provides referral to supplemental health services.".

(b) Section 330 is amended by adding at the end thereof the following:

"(h) (1) The Secretary may make grants, to community hospitals to assist such hospitals in planning, developing, and operating primary care centers in urban areas.

"(2) To be eligible for a grant under this subsection, the community hospital must submit an application which contains or is supported by the following assurances, satisfactory to the Secretary:

"(A) that, to the extent practicable, facilities and equipment located in existing emergency rooms, outpatient departments, and other sections of the hospital shall be converted or have been converted for use in the primary care center; and

"(B) that appropriate emergency room and outpatient services will be maintained or have been maintained after the conversion; and

"(C) that the primary care center will be maintained as a separate and distinct cost unit, from such community hospital.

"(3) Funds for grants under this subsection may be used for covering costs associated with (A) planning, (B) developing (including modernization, renovation of space, and construction), and (C) operating primary care centers.

"(4) The Secretary may not approve an application for a grant under this subsection unless the application contains assurances that the primary care center will be operated in accordance with all the requirements for community health centers in subsection (e), except for subsection (e) (2) (G).

"(5) The Secretary may not approve an application for a grant under this subsection unless the application contains, in addition to the assurance pursuant to paragraph

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(4), the following assurances: the primary care center must have an advisory board which is composed of individuals a majority of whom receive their medical care at the center. The board shall meet regularly, but no less than six times per year, to review the operations of the center and to develop recommendations to the hospital's governing board concerning the types of services to be provided and the operation of the center.

"(6) There are authorized to be appropriated for the purpose of making payments for grants under this subsection $34,000,000 for the fiscal year ending September 30, 1979, $72,000,000 for the fiscal year ending September 30, 1980, and $114,000,000 for the fiscal year ending September 30, 1981. No more than 30 per centum of the funds appropriated in any fiscal year may be used for planning and development (including construction, modernization, and renovation).".

(c) Section 330(g)(1) (relating to authorizations for the planning and development of community health centers) is amended by striking out "and" after "1977,", and inserting before the period at the end of the sentence thereof the following: ", $10,000,000 for the fiscal year ending September 30, 1979, $10,000,000 for the fiscal year ending September 30, 1980, $10,000,000 for the fiscal year ending September 30, 1981, $10,000,000 for the fiscal year ending

September 30, 1982, and $10,000,000 for the fiscal year ending September 30, 1983".

(d) Section 330(g)(2) (relating to authorizations for the operation of community health centers) is amended by striking out "and" after "1977,", and inserting before the period at the end of the sentence thereof the following: ", $320,000,000 for the fiscal year ending September 30, 1979, $352,000,000 for the fiscal year ending September 30, 1980, $387,200,000 for the fiscal year ending September 30, 1981, $425,900,000 for the fiscal year ending September 30, 1982, and $468,500,000 for the fiscal year ending September 30, 1983".

NATIONAL HEALTH SERVICE CORPS

SEC. 107. (a) Section 338(a) (relating to authorization for the National Health Service Corps) is amended by striking out "$57,000,000" and substituting in lieu thereof $64,000,000".

(b) Section 336 (relating to annual reports to Congress) is amended by (1) inserting after "SEC. 336." "(a)", and (2) by inserting at the end of subsection (a) thereof the following:

"(b) In addition to the report required by subsection (a), the Secretary shall submit a special report, developed through consultation with the National Advisory Council on the National Health Service Corps (as defined in section

337), to the Committee on Human Resources of the Senate and to the Committee on Interstate and Foreign Commerce of the House of Representatives on February 1, 1979. Such special report shall delineate the present and future directions of the National Health Service Corps particularly its relationship as a health manpower program and as a health services delivery program, analyze the use of corpsmen in the various settings defined in section 332, address the use of the Corps in meeting urban and rural health needs, and project the estimates of the Corps' manpower and their use through 1985.".

GENETIC DISEASES

SEC. 108. Section 1101 (b) (relating to authorizations for grants and contracts for testing and counseling, information and education programs to genetic diseases) is amended (1) by striking out "and" after "1977,", and (2) striking out "for fiscal year 1978" and inserting in lieu thereof the following: "for the fiscal year ending September 30, 1978, and $30,000,000 for the fiscal year ending September 30, 1979".

HEMOPHILIA

SEC. 109. (a) Section 1131 (f) (relating to authorization for hemophilia programs) is amended by striking "and" after "1977,", and inserting before the period at the end of the sentence thereof the following: ", $5,000,000 for the fis-

cal year ending September 30, 1979, $5,500,000 for the fiscal year ending September 30, 1980, and $6,500,000 for the fiscal year ending September 30, 1981".

(b) Section 1131(e) (relating to authorizations for blood separation centers) is amended by striking "and" after "1977", and inserting before the period at the end of the sentence thereof the following: ", $3,900,000 for the fiscal year ending September 30, 1979, $4,290,000 for the fiscal year ending September 30, 1980, and $4,712,000 for the fiscal year ending September 30, 1981".

HOME HEALTH SERVICES

SEC. 110. (a) Title III is amended by inserting after section 319 the following new section:

"HOME HEALTH SERVICES

"SEC. 320. (a) (1) For the purpose of demonstrating the establishment and initial operation of public and nonprofit private agencies (as defined in section 1861(o) of the Social Security Act) which will provide home health services (as defined in section 1861(m) of the Social Security Act) in areas in which such services are not otherwise available, the Secretary of Health, Education, and Welfare may, in accordance with the provisions of this section, make grants to meet the initial costs of establishing and operating such agencies and expanding the services available through existing agencies, and to meet the costs of compensating

professional and paraprofessional personnel during the initial operation of such agencies or the expansion of services of existing agencies.

"(2) In making grants under this subsection, the Secretary shall consider the relative needs of the several States for home health services and preference shall be given to areas within a State in which a high percentage of the population proposed to be served is composed of individuals who are elderly, medically indigent, or both.

"(3) Applications for grants under this subsection shall be made in such form and contain such information as the Secretary shall prescribe by regulation.

"(4) Payment of grants under this subsection may be made in advance or by way of reimbursement or in installments as the Secretary may determine.

"(5) There are authorized to be appropriated $8,000,000 for the fiscal year ending September 30, 1978, $12,000,000 for the fiscal year ending September 30, 1979, $12,000,000 for the fiscal year ending September 30, 1980, and $12,000,000 for the fiscal year ending September 30, 1981, for payments under this subsection.

"(b) (1) The Secretary of Health, Education, and Welfare may make grants to public and nonprofit private entities to assist them in demonstrating the training of professional and paraprofessional personnel to provide home health serv-

ices (as defined in section 1861 (m) of the Social Security Act).

"(2) Applications for grants under this subsection shall be in such form and contain such information as the Secretary shall by regulations prescribe.

"(3) Payment of grants under this section may be made in advance or by way of reimbursement, or in installments, as the Secretary shall determine.

"(4) There are authorized to be appropriated $2,000,000 for the fiscal year ending September 30, 1978, $2,000,000 for the fiscal year ending September 30, 1979, $2,000,000 for the fiscal year ending September 30, 1980, and $2,000,000 for the fiscal year ending September 30, 1981, for payments under grants under this subsection.".

(b) Section 602 of Public Law 94-63 is repealed.

LEAD-BASED POISONING PREVENTION

SEC. 111. Section 503 of Public Law 91-695 (relating to authorizations for lead-based paint poisoning prevention programs) is amended (1) by striking out "and" after "1977.", and (2) striking out "for fiscal year 1978" and inserting in lieu thereof the following: "for the fiscal year ending September 30, 1978, and $14,000,000 for the fiscal year ending September 30, 1979".

Senator KENNEDY. I am hopeful that the witnesses today, and at hearings scheduled for March 1, will discuss constructive improvements in these expiring authorities, so that we can move forward to strengthen the health services delivery systems available for underserved areas and populations, and for control and prevention of special diseases.

Senator HATHAWAY. Our first witness is Dr. Julius Richmond, accompanied by Dr. Joyce Lashof, George Lythcott, William Foege, and Karen Davis. Doctor, go ahead.

STATEMENT OF JULIUS B. RICHMOND, M.D., ASSISTANT SECRETARY OF HEALTH, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, AND SURGEON GENERAL OF THE PUBLIC HEALTH SERVICE, ACCOMPANIED BY JOYCE LASHOF, M.D., DEPUTY ASSISTANT SECRETARY FOR HEALTH; GEORGE LYTHCOTT, M.D., ADMINISTRATOR OF THE HEALTH SERVICES ADMINISTRATION; WILLIAM FOEGE, M.D., DIRECTOR, CENTER FOR DISEASE CONTROL, AND KAREN DAVIS, PH.D., DEPUTY ASSISTANT SECRETARY FOR PLANNING AND EVALUATION

Dr. RICHMOND. Well, thank you, Mr. Chairman. I am pleased to have the opportunity to appear before this subcommittee again this morning. Your hearing concerns statutory authorities for Federal programs providing health services and disease prevention and control. These programs include the community health centers, migrant health centers, comprehensive public health grants to States, hypertension, immunization, venereal disease, and other disease control programs.

For the most part, they are administered in two agencies of the Public Health Service: the Health Services Administration and the Center for Disease Control. Accordingly, Mr. Chairman, I am accompanied this morning by Dr. George Lythcott and Dr. William Foege, respectively, Administrator and Director of those two agencies. In addition, I am accompanied by Dr. Joyce Lashof, Deputy Assistant Secretary for Health Programs, and Dr. Karen Davis, Deputy Assistant Secretary for Planning and Evaluation for Health Programs.

In my prepared statement, I will briefly describe the current status and achievements of, and legislative proposals for, our service delivery, capacity building, and public health and disease control activities. Following that, my colleagues and I will be happy to respond to your questions.

In the interest of time, Mr. Chairman, I will summarize various portions of my testimony, and submit the full statement for the record, so that we will try to be brief.

As the members of this subcommittee know, these service delivery and disease prevention programs provide us with some of the most direct Federal links to the everyday health care problems of individuals. Due in large measure to the compassionate leadership of this subcommittee, the accomplishments of the subcommittee can be meas-

ured by the improved quality of health for the populations in our country in greatest need.

I would first like to discuss our capacity building programs. Our federally funded primary care programs include community health centers, migrant health, health underserved rural areas, maternal and infant care, and children and youth programs. As of 1977, a total of 5.7 million persons were being reached through the Health Services Administration's capacity building programs. This represents an increase of over 75 percent since 1975. Eighty percent of these people are poor; 85 percent of them are members of minority groups.

However, these programs do not yet fill the needs of all underserved areas, Mr. Chairman. An estimated 45 million Americans live in approximately 7,200 medically underserved areas; 56 percent of these persons are in rural areas, and 44 percent are in urban areas.

During a relatively short life span, the capacity building efforts have demonstrated their flexibility in providing health care which integrates health services, health and nutrition education, social services, mental health counseling, and environmental services into a more efficient and cost-effective delivery system.

We will propose 3-year extensions for the community health center and migrant health programs, Mr. Chairman, at an authorization level of $301 million for community health centers, and 34.5 million for migrant health for fiscal 1979, and such sums as may be necessary for the following 2 years.

Closely linked to our capacity building programs is the National Health Service Corps, which will provide significant staffing, as we expand the number of centers. The National Health Service Corps scholarship program assignees, as well as other Corps recruits will also provide health services in manpower shortage areas to patients in a variety of settings. Those include public health facilities and Indian Health Service facilities.

We are using National Health Service Corps personnel, including nutritionists, public health nurses, and medical social workers, on assignment with local and district health departments to assist them in planning and carrying out programs.

For the National Health Service Corps, we request an increase in the 1979 authorization from $57 million to $64 million to accommodate the number of corps personnel who will be available for assignment in fiscal year 1979. The existing authorization level for fiscal year 1980 is considered adequate for an anticipated field strength of up to 3,000 in the corps.

Before I move on to the discussion of our disease control and prevention activities, I would like to speak to the urban health care problems addressed in section 106 of your bill, Mr. Chairman; in particular, you address the need to enhance the ability of urban hospitals in underserved areas to provide comprehensive primary care services.

As you know, the poor in these underserved areas often use the hospital outpatient department and emergency room for the delivery of primary care, rather than for the specialized services for which they were designed. Not only has this resulted in many individuals

not receiving appropriate primary care services, but it has also contributed to the generation of considerable deficits in these hospitals.

We support the conceptual basis of your subcommittee's proposal, because we believe the community health center program provides the flexibility necessary to relate the hospital setting. Your approach would greatly enhance our capacity to demonstrate more effective ways to deliver comprehensive primary services to the inner-city poor, and to provide a degree of fiscal relief to these hospitals.

However, the administration is still considering an urban initiative in health, and we would thus be opposed to any additional specific earmarking in current programs. We believe there are sufficient funds to begin to work with the urban hospitals in 1979. However, we must await the President's decision before commenting on the higher authorization level proposed in your bill.

Several other legislative authorities are under consideration, which I describe in more detail in my statement. They include home health care, hypertension, hemophilia, and genetic diseases.

I would just like to make on final comment regarding the importance of our capacity building programs in meeting the needs of special initiatives underway to improve immunization levels and adolescent health. We expect the Bureau of Community Health Service programs to be a major delivery resource for improved family planning services, maternal, and child health programs, and increasing immunization rates. We also anticipate providing necessary services for the CHAP program when it is enacted by the Congress.

I would now like to address the area of disease prevention and control. As you know, Mr. Chairman, this administration is committed to incorporating prevention as the heart of a comprehensive strategy for improving the health of the American people. Both Secretary Califano and I are committed to bringing more knowledge to the area of prevention, and at the same time applying most effectively what we do know.

Perhaps nowhere is the challenge better evidenced than in our community prevention programs, which are charged with carrying out outreach, epidemiologic assessment, surveillance, community organization and health education, and insuring that high-risk population groups receive appropriate preventive services. We are determined to creatively structure the most effective and responsible delivery of these services.

In my prepared statement at this point, I set out certain accomplishments of the Center for Disease Control in the area of immunization, venereal disease control, lead base paint poisoning, and rat control. I will not present that section now, in the interest of time, Mr. Chairman, but will be happy to answer any questions you may have, and I will move on into the prepared statement to approximately page 15.

Your subcommittee currently has a bill under consideration which proposes a 1-year extension of the disease control and prevention authorities. While we would be opposed to enacting a simple 1-year extension of these authorities at this time, it is our understanding that the legislation was introduced in its present form primarily to provide time to develop a more comprehensive prevention initiative later this spring.

We understand that you are in the process of consulting with interested outside groups, and that you will be proposing legislation in the near future. Accordingly, rather than commenting further on the 1-year extension, I will outline our own prevention proposals and express the hope that we can work closely together in this vital health care area.

We will soon be submitting legislation to you, Mr. Chairman, proposing a consolidation of existing disease prevention and control programs into a single annual grant to the States. This comprehensive grant will consolidate existing authorities for disease control—lead based paint poisoning, venereal disease control, rat control, immunizations, and the comprehensive public health services grant to States. Except for hypertension and mental health planning, we are proposing that consolidation.

We believe that States should be assisted in meeting the costs of providing required disease control and prevention programs of high national priority. We would expect to require the States to specifically earmark a portion of their grant for childhood immunization activities.

With regard to other disease prevention and control activities, however, States must be given sufficient flexibility so that they can determine which priority problems should be addressed with these Federal funds. While States will thus be afforded considerable flexibility to set their own prevention spending priorities for the Federal dollars they receive, flexibility will have to be balanced with the need for accountability.

In order to achieve such balance, we will recommend that State health planning activities under Public Law 93-641 and, in particular, the requirement for development of a coordinated State health plan, address the extent of the need for preventive health programs and services and that States submit plans to spend the money they would receive from this program in accordance with the needs identified in those plans.

The Secretary would approve the plan prior to allocating these funds. We also favor incorporating audit and reporting mechanisms so that the Congress and the Secretary can review and examine whether funds are spent for appropriate preventive services identified in the State's plan and approved application.

Incorporating the section 314(d) authorities into this comprehensive State grant would allow the States to continue to spend that money on needed preventive health activities. It recognizes that certain of those traditional activities may require Federal funding in some States, but not in others.

I want to emphasize that we are looking forward to working closely with this subcommittee in further refinement of this legislation. I and my colleagues thank you for the opportunity to testify on these vital health care delivery and prevention issues today. We will submit a table, including the administration's proposed authorization levels for fiscal year 1979 for the subcommittee to review. We will shortly be submitting extension legislation.

We will welcome, Mr. Chairman, any questions.

Senator HATHAWAY. Doctor, are you saying that under the block grant proposal which you are going to make, there are no national

priorities and that we just give it to the States to do what they want, and that they are going to set all the priorities?

Dr. RICHMOND. No, Mr. Chairman. We would certainly want to ask the States to focus on national priorities that we think are of importance; for example, the immunization initiative that we now have underway. We want to be certain that certain national priorities of that nature are well attended to. On venereal disease control—a current epidemiologic problem—we certainly would look hard at their plans. We would certainly want to see to it that the individual States are attending to the important national priorities, and that is the reason for asking for a State plan, that we so review and the Secretary can approve the State plan.

Senator HATHAWAY. They have to submit to you a State plan, but that cannot be too specific, because they do not know what the problems are going to be in the future. So if they spend a whole lot of money on something that you do not think they ought to be spending money on, there is nothing much you can do about it, is there, once you approved the States plan?

Dr. RICHMOND. Well, again, we would be asking, Mr. Chairman, for audits and reports as to how the funds have been expended. I should also mention, Mr. Chairman, that we are in the process of developing a rather close liaison program with all of the State health officers. Dr. Lashof, as my deputy for health programs, and I have invited all of the State health officers to design a plan through their organization, the Association of State and Territorial Health Officers, to meet with us on a regular basis. And we would hope, through such communication processes and through the review of their plans and the audit of what they do, that they would not be off target in terms of the public health priorities of the Nation.

Senator HATHAWAY. Now, for how long a period of time are you recommending this—3 years?

Dr. RICHMOND. Three years, yes, sir.

Senator HATHAWAY. The apprehension I have is once you start down that road, it is very difficult to go back to a categorical program, once you start on a block grant program. I would think that we would go very slow with respect to that, to make sure that our priorities are guarded, and not just by some agreement that you may have with the State. They do not have anything over their heads to prevent them from doing whatever they want to do, which may or may not be in the national interest.

Dr. RICHMOND. Well, Mr. Chairman, your concerns have been concerns we have discussed in the Department rather extensively, and we do feel that national priorities need to be set, and we think, through a continuing dialog, the States will be responsive. We do feel that since there are individual variations in States—that is, not all of the problems are equally distributed across the 50 States—that it becomes important to try to introduce some flexibility.

We think that we need to learn how to fine-tune our efforts at the State and local level to really target our efforts more effectively, and that is the reason we are moving in this direction.

Senator HATHAWAY. Well, will there be any retained funds at the Federal level for special priorities?

Dr. RICHMOND. Well, we have not as yet made a judgment about that.

Senator HATHAWAY. I would hope you would consider that, because I think it might be necessary. It seems to me that if you are worried about the States having flexibility, that we ought to continue on a categorical basis and put the onus on the States to come back to us for approval to transfer funds, and in that way, we would have better control, and at the same time we would provide for flexibility. I understand that various States are going to have different problems and that they would like to transfer funds, and I am not against that, but I think that it ought to be done on an ad hoc basis, rather than just giving them all the money and saying, "You can spend it any way you want."

You know we had problems under 314(d); no information of how the funds were being spent. I assume that you recall that, and that there is something in your recommendation to take care of that accountability.

Dr. RICHMOND. Yes, sir. I think your suggestion is a good one and it is one that I think we would want to consider.

Senator HATHAWAY. Now, the Kennedy bill extends the community and migrant health center program for 5 years, and you are proposing 3. It seems to me that if you believe that these are good programs, that the longer period of time is warranted. Why are you cutting it off to 3 years?

Dr. RICHMOND. Well, Senator Hathaway, it is our view that the 3-year period provides enough operational time to warrant a review of how effectively the programs are operating, to really assess how they are functioning. While we certainly would not look forward to discounting these programs at the end of 3 years, we think an opportunity to reassess at the end of 3 years would be very useful.

We are learning a good deal about how to deliver these services more effectively. We are certainly learning how to improve the comprehensive nature of these services. We are learning, certainly, how to build preventive services into these programs and as we learn more, I think we may want to take the opportunity at the end of a period like 3 years to see if we can redirect these programs to become even more effective.

Senator HATHAWAY. Well, lengths of time, I suppose, are always debatable, anyway. I suppose it is very difficult to come up with the right answer. It just seems that a 5-year period would give these programs a better chance to grow, and then evaluate them. You know, it is just those two programs we are talking about; others are of shorter duration.

Let me ask you something about the National Health Service Corps. How many new scholarship recipients will there be in 1979?

Dr. RICHMOND. We expect to add at least 450 scholarship people to the Corps in 1979. In terms of the specifics concerning scholarship recipients, do you have that number, Dr. Lythcott?

Dr. LYTHCOTT. We are at about half and half right now, sir.

Dr. RICHMOND. About fifty percent serving in the Corps in 1979 will be scholarship recipients, and 50 percent will be volunteers.

Senator HATHAWAY. How many?

Dr. RICHMOND. Fifty-fifty.

Senator HATHAWAY. New ones, I am talking about; new scholarships.

Dr. RICHMOND. We will have 1,725 assignees.

Senator HATHAWAY. Those are not all new, though. How many of those are new?

Dr. RICHMOND. 300 will be new scholarships for exceptionally needy students.

Senator HATHAWAY. 300?

Dr. LYTHCOTT. Yes, and in addition 900 new contracts will be awarded in 1979.

Senator HATHAWAY. It will be 300 new scholarships that will be awarded in 1979?

Dr. LYTHCOTT. There will be about 300 scholarships awarded to persons who received their first year of support under a special provision for scholarships for students of exceptional financial need. This will be their first year of support under the National Health Service Corps scholarship program so, I guess they could be considered new awards. In addition to these 300 awards there will be another 900 new awards.

Senator HATHAWAY. Is that a reasonable figure, or could that be increased?

Dr. LYTHCOTT. Well, I think it is a reasonable figure for now although we are constantly reassessing our needs. The number of scholarship men and women will increase as the years go by. We anticipate a larger number of scholarship people as compared to volunteers as we go down the line.

Senator HATHAWAY. How does that compare with the past year?

Dr. LYTHCOTT. It has been more volunteer, and the scholarship is becoming about equal, sir.

Dr. LASHOF. It might help to clarify a little bit the difference in your question as to whether you were talking about new scholarship awardees that were actually awarded scholarships in school versus those coming out of the program and ready for field placement. I think that is where some of the confusion on figures is.

There will be, in 1979, 900 new awards made to students in school for scholarship award; actually coming out, having finished their schooling and having done their postgraduate residency training and available for field assignment in 1979 will be 450. That is where the differences in figures are.

Senator HATHAWAY. I see. Thank you. Now, it has been alleged that a disproportionate share of the community health center funds provided under section 330 are allocated to urban health centers. Can you give us a breakdown for the most recent fiscal year of the number of projects that have been funded and the amount of funds expended in, first, urban comprehensive community health centers, then rural comprehensive community health centers, and rural health initiative projects and urban health initiative projects? Do you have that with you, or can you supply it for the record?

Dr. LASHOF. We have all the figures here, but maybe you would prefer for us to submit a table to you with them broken down, rather than trying to read them all off to you?

[The information referred to appears on p. 91.]

Senator HATHAWAY. Well, can you answer my question as to whether or not the allegation is true that a disproportionate share of the money is going to urban, rather than rural?

Dr. LASHOF. I do not know how you define "disproportionate." The urban projects——

Dr. RICHMOND. Dr. Lythcott has those figures.

Dr. LYTHCOTT. I do not know how you define "disproportionate" but the ratio of dollar expenditures is about 8 to 5 now, sir, of the urban versus rural, in numbers.

Senator HATHAWAY. Eight to five?

Dr. LYTHCOTT. Yes, approximately.

Senator HATHAWAY. Eight dollars to every five?

Dr. LYTHCOTT. Actually, for CHC, the ratio we anticipate for fiscal year 1979 expenditures is 68 percent urban and 32 percent rural. But, for health services projects overall, including migrant health, health underserved rural area projects and the National Health Service Corps the ratio is closer to 55 percent urban and 45 percent rural.

Senator HATHAWAY. I see. How about on the basis of service on the number of people involved? Do you have any breakdown along that line?

Dr. LYTHCOTT. We have it here. We have to provide it for the record; I would have to dig it out.

[The information follows:]

Table 1
Rural and Urban Breakout of the Community Health Centers

Community Health Centers	1977 Projects No.'s	1977 Projects % of Total	1977 Funding $	1977 Funding % of Total	1978 Projects No.'s	1978 Projects % of Total	1978 Funding $	1978 Funding % of Total	1979 Projects No.'s	1979 Projects % of Total	1979 Funding $	1979 Funding % of Total
On-going CHC's												
Rural	45	10%	$ 40,470	19%	45	8%	$ 44,408	18%	45	6%	$ 52,347	18%
Urban	113	25%	$143,484	67%	113	20%	$157,445	64%	113	16%	$165,767	58%
RHI	262	58%	$ 23,599	11%	356	62%	$ 31,187	13%	441	63%	$ 39,688	14%
UHI	35	7%	$ 7,595	3%	60	10%	$ 13,960	5%	106	15%	$ 28,198	10%
CHC Total	455	100%	$215,148	100%	574	100%	$247,000	100%	705	100%	$286,000	100%
Rural	307	67%	$ 64,069	30%	401	70%	$ 75,595	31%	486	69%	$ 92,035	32%
Urban	148	33%	$151,079	70%	173	30%	$171,405	69%	219	31%	$193,965	68%

Community Health Centers
Rural/Urban

	1977			1978		
	Projects	People Served 000's	Funding 000's	Projects	People Served 000's	Funding 000's
Ongoing CHCs						
Rural	45	504	$40,470	45	537	$44,408
Urban	113	1,596	143,484	113	1,699	157,445
Subtotal	(158)	(2,100)	(183,954)	(158)	(2,236)	(201,853)
RHI	262	1,149	23,599	356	1,854	31,187
UHI	35	175	7,595	60	475	13,960
Total all Centers	455	3,424	215,148	574	4,565	247,000
Rural	(307)	(1,653)	(64,069)	(401)	(2,391)	(75,595)
Urban	(148)	(1,771)	(151,079)	(173)	(2,174)	(171,405)

NHI Study data indicate users and their families in:

Rural areas - 97% Black, 57% female, 43% under 17, 62% BCHS facility usual source of care

Urban areas - 81% Black, 59% female, 47% under 17, 71% BCHS facility usual source of care

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Senator HATHAWAY. Is it roughly equivalent?

Dr. LYTHCOTT. Larger numbers are served in rural areas, generally, then are served in the urban areas.

Senator HATHAWAY. Larger numbers are being served?

Dr. LYTHCOTT. Yes, in 1978 in the CHC program we anticipate that 2,391,000 persons will be served in rural areas and 2,174,000 persons will be served in urban areas.

Senator HATHAWAY. Now, as you know, Senator Javits has introduced an amendment calling for the establishment of an urban health initiative as a part of the community health program. Would the existing need for such services in rural medically underserved areas justify the broadening of this proposed program to include both urban and rural community hospitals as recipients of this financial assistance, or the establishment of a similar program to meet the special needs of rural communities?

Dr. RICHMOND. Well, Senator Hathaway, we still have large underserved or unserved populations in urban centers, and our considerations in the urban initiative reflect our concern for the need to extend those services and, there, we are considering the potentialities, of course, of using hospitals in central cities, their outpatient departments, and also developing satellite units in addition to the existing community health centers.

In the rural areas, in addition to the development of centers, we think that the National Health Service Corps approach does provide us with a great deal of flexibility to meet the needs of rather sparsely settled areas where the population is rather thinly distributed. So, we see ourselves as going in both directions, because there are great needs in both the rural and the urban areas.

Senator HATHAWAY. Let me ask you a question on the migrant health centers. The administration budget includes $3 million for hospitalization for migrants. It does not seem to me that that is going to be sufficient, because what happens with migrants who cannot meet the residency requirements for State-funded programs that need to be hospitalized? I am just wondering why no additional funding has been requested in that particular area.

Dr. RICHMOND. Senator, we are proposing some legislation—I might ask Dr. Lashof to comment on it—that would deal with this matter of residency requirements. Do you want to comment on that, Dr. Lashof?

Dr. LASHOF. Just briefly, the Health Care Financing Administration will be proposing some legislation to deal with the problem of resident status as a barrier to services for the migrant population. If that legislation is successful, we would assume that the problem of hospitalization for the migrants would be addressed in that way and that it would be able to be picked up under the medicaid program. If that is not successful, then I think you have, indeed, identified a problem. But we are, at this point, expecting that that legislation will deal with that problem.

Senator HATHAWAY. Now, when will this proposal be before us?

Dr. LASHOF. It is in the hands of the Health Care Financing Administration, so I cannot tell you exactly. I assume it is going forward. We met with them about it, and it is to deal specifically with

the problem where one State claims that the migrant is not a resident, so that State will not pick it up, and the other State says, "They are not a resident here either and we will not pick it up." The exact wording and the exact methodology they are planning to use, I do not know, but that is the problem they intend to address.

Dr. RICHMOND. Dr. Davis has a comment.

Senator HATHAWAY. Yes, Karen?

Dr. DAVIS. That proposal has been approved by the administration; it is part of the President's budget. We estimate that it would cost about $8 million in fiscal 1979. There are legislative amendments being forwarded to the appropriate authorizing committees to deal with that problem.

Senator HATHAWAY. I see. Thank you. Now, in the New York Times last week, it was reported that you are sending at least 20 physicians from the National Health Service Corps into New York City next year. So far, almost all members of the corps have gone to rural areas; approximately 94 percent. Your new policy would put 60 percent in the inner city. How can you make such a rapid switch in placement?

Dr. RICHMOND. Senator Hathaway, I do not know where your 60-percent figure comes from.

Senator HATHAWAY. I guess it comes from the New York Times.

Dr. RICHMOND. There is no policy on that. It was in the New York Times, but I do not know where that reporter got that figure. There has been no policy decision.

Senator HATHAWAY. It is part of all the news that is fit to print; I do not know that that necessarily means it is true. So, the 60 percent is off?

Dr. RICHMOND. Oh, yes.

Senator HATHAWAY. What kind of a switch, percentagewise, do you intend to make?

Dr. RICHMOND. Well, we are moving slowly on this matter of redistribution. This issue is more complex than at first meets the eye, Senator Hathaway, because we do take into the Corps volunteers, and we try to make a match between the volunteer and the area of need. A number of people are volunteering who prefer to serve in urban areas, and we do not deny them that opportunity.

So, we cannot be absolutely certain as to how many we will ultimately have in urban areas. I think it is fair to say that, as a policy matter, we do not want to lose the concentration on the rural areas, because we think we have really made some impact there and we would not want to diminish that.

Senator HATHAWAY. Yes, I think you have, too, and I do not want to see that neglected, understanding full well the problems of the inner cities. I think the figure was that 60 percent of the new assignments would be to urban areas. Even that is not true?

Dr. LASHOF. That is not correct.

Dr. RICHMOND. That is not the policy.

Senator HATHAWAY. Well, you mentioned that some of them volunteer for this, but do you have any plan for an orderly transition, or increase in urban over rural?

Dr. RICHMOND. Well, we are projecting—and, of course, we have to make some guesses about this—but in 1979, we would think it would be 85 percent rural and about 15 percent urban; and in 1980, perhaps 80 percent rural and 20 percent urban.

Senator HATHAWAY. Do you think that that is a fair mix?

Dr. RICHMOND. Yes, I think that is a reasonable mix, not because we want to neglect the urban areas, Senator Hathaway, but we do think that since there are health providers in urban areas who may not currently be working among the underserved population—in other words, in the central city areas—we are looking at ways by which we can provide incentives for those people, not necessarily through the Corps exclusively, to work in those areas.

So, it does not mean we are minimizing the problem of providing services to people in the central cities, but we do not think it will have to come predominately from the Corps.

Senator HATHAWAY. Now, along the same line, I know that you are meeting the needs of the Indian health service unit, but how about some others, like community mental health centers and State mental hospitals and federal prisons?

Dr. RICHMOND. We are looking at the needs that are developing there, Senator Hathaway, particularly if one looks at the potential need in publicly financed hospitals, as we cut off the inflow of foreign medical graduates. Such graduates have been staffing some of those hospitals in relatively significant numbers. It may well be that there will be some critical needs there for physicians, and if that does become acute, we would certainly consider the assignment of National Health Service Corps physicians and other health providers to those settings.

Senator HATHAWAY. You do not think there is a need right at the present time?

Dr. RICHMOND. Well, for example the State mental hospitals have traditionally been poorly staffed, so that there is a need. However, the needs are very vast and we are not sure that a strategy using the Corps would be a relevant solution to the State hospital problems. But we would be wanting to look at critical areas where there are some real problems. And, again, we are not insensitive, I might say, to the needs of the State mental hospitals, but our Alcohol, Drug Abuse, Mental Health Administration is looking at those problems. And our community mental health center programs, we hope, will begin to deal with the State mental hospital needs more effectively.

Senator HATHAWAY. Is there an overall plan for taking care of these needs?

Dr. RICHMOND. Well, we hope that with the recommendations that we discussed yesterday, which will be coming from the President's Commission on Mental Health, that we will be developing more comprehensive design for mental health services.

Senator HATHAWAY. That will be out in April?

Dr. RICHMOND. Yes, in April. As you may recall, we are looking forward to linking those services with the health service system much more intimately.

Senator HATHAWAY. What about the Federal prison problem?

Dr. RICHMOND. Well, this is an area where we are reviewing the needs. Some National Health Service Corps personnel could be as-

signed to those areas, because there are some critical needs. It has not been a particularly popular area for health providers to work. We may well have to rely on our Corps personnel for some of those services. We are looking at that.

Senator HATHAWAY. You are looking at it, but is there some kind of a plan to do something about it?

Dr. RICHMOND. We will be developing a plan, Senator Hathaway. Perhaps Dr. Lythcott wants to comment on that.

Dr. LYTHCOTT. The Bureau of Medical Services, sir, has been providing medical support for the Bureau of Prisons. We have had the total responsibility for that. Fairly recently, we were asked to reduce that interest over a 3-year period until it is phased out. We have requested that we be allowed to stay in the area, and that is in the mill now and I am hopeful that we will be able to continue full support for the Federal prisons health program, with our own service officers and, if need be, National Health Service Corps people, as well.

Senator HATHAWAY. Now, let me ask you a question on the administration of this program. The National Health Service Corps is under the Bureau of Community Health Services, but the scholarship program is administered in the Bureau of Health Manpower. Does that cause any problems?

Dr. RICHMOND. I might ask Dr. Lythcott to comment on that.

Dr. LYTHCOTT. The two agencies, both at staff and at senior level, work very closely together, sir, and we have had no problems at all in doing this.

Senator HATHAWAY. There is no need for a consolidation or a separate agency?

Dr. LYTHCOTT. No, sir.

Senator HATHAWAY. Now, one last question on this general problem: Many students come out of medical school with excellent clinical knowledge, but little knowledge of the situation that they are going to face. I just wonder what you are presently doing to help to ease the transition for them.

Dr. LYTHCOTT. Well, Senator, most, if not all, of our units are related either to teaching centers or to other hospitals where patients can be hospitalized. And with that relationship between the more senior physician and the younger men who come in, we intend to bridge the gap between what they do not know when they come in, and perhaps to learn what it is all about.

By the time a physician is placed in a Corps site he or she has generally completed residency training and has had several years experience in responsible patient care. In addition, we provide directly and through contracts a variety of assistance including pre-assignment conferences, and assistance in setting up a practice and medical management systems. In addition, continuing relationships with educational institutions are being developed to reduce professional isolation and continue the professional education of the Corps assignees. Area Health Education Centers assist in this also. Also, we are working on the identification and elimination of spouse displeasure, cultural and personality clashes to help us to begin to work on easing these types of problems in Corps assignments.

Dr. RICHMOND. Dr. Davis would like to comment on that.

Dr. DAVIS. We also have several programs to try to acquaint students with rural areas during their period of training. We are spon-

soring, of course, the area health education center program which establishes training centers throughout the States so that medical students and other types of health professional students can rotate through the centers and get some experience with rural areas prior to that time.

We also have, of course, the family practice residency and primary care residency programs, so the students do have an opportunity through this period of their training to become acquainted with rural areas.

Senator HATHAWAY. Are these keyed to certain geographical areas, or are you just saying rural areas, in general? Could a doctor find out what the problems are in Alaska or North Dakota or Maine, or wherever?

Dr. DAVIS. That is right. They have had, particularly in the area health education center program, a very strong rural focus to try to acquaint students with these areas during their training.

Dr. RICHMOND. In the health manpower legislation, too, that requires, ultimately, 50 percent of the training physicians to go in the direction of primary care, there is the specification that some of that training be in remote sites from the medical centers, so that the ultimate pressure is there to get the students out into places at some distance from the medical centers so that they gain some experience in other kinds of communities.

Senator HATHAWAY. One last group of questions; I just wanted to find out what you are doing with respect to the Russian flu. I suppose Dr. Foege could better answer that.

Dr. FOEGE. We do have isolates now on the Soviet flu from Wyoming, from Colorado, from West Point, New York, and from Michigan. And then, of course, this morning we have clinical evidence that has been submitted from Annapolis. A series of meetings have been held, starting in December, and the last one was held Monday of last week, with flu experts from university centers and also people from State health departments as well as representatives from a variety of groups—NIH, COC, the Food and Drug Administration.

They met to look at this and they have made some recommendations to the Department that a program on influenza be contemplated, not specifically for Soviet flu, but a program that would provide ongoing influenza immunizations for high-risk groups each year, but starting this fall with the Soviet flu as one of the components.

Senator HATHAWAY. But does this high-risk group not change? This is just newspaper talk, but I understand the Russian flu has affected more young people, who are normally not in the high-risk group.

Dr. FOEGE. There is one high-risk group that does not change for any strain of influenza A. It consists of two types of people—those who have a chronic medical condition, and those who are over the age of 65. With the current Soviet strain, the individuals under the age of about 24 have had no previous experience with this strain, so they are considered to be at a different risk than older people. Therefore, the first priority, we feel, should be given to persons under 24 who have a chronic medical condition. That is what the group recommended last week.

We have now gone to all State health officers and asked them for comments on the recommendations of this group, and specifically what recommendations they would have for carrying out an annual program aimed at high-risk groups. We expect the comments by the end of this week, and the Department will then look at the recommendations from last week and the recommendations from the State health officers, and present a proposal.

Senator HATHAWAY. I see. What percentage of the population do you think would have this available to them?

Dr. FOEGE. The committee last week listed three priorities, the first priority being persons under the age of 24 with chronic medical conditions, which would be about 4½ million people; the second priority being persons over the age of 25 with chronic medical conditions, which would be an additional 14½ million people; and, finally, persons over the age of 65, which would be an additional 23 million people. So, the high-risk group would consist of about 43 or 44 million people.

Senator HATHAWAY. About 20 percent of the population.

Dr. FOEGE. That is right.

Senator HATHAWAY. And you think that is going to be sufficient?

Dr. FOEGE. Traditionally, we have only been able to reach about 20 percent of the high-risk group in the country. The committee feels that it is probably not an attainable goal to reach the entire high-risk group this year, and they are proposing that we begin a program which would double the population reached from 20 percent to 40 percent of the high-risk group during the coming year.

Senator HATHAWAY. What is the likelihood of side effects from the immunization? I know that there were some a year or so ago on the immunization program.

Dr. FOEGE. We would expect that the new vaccine containing the Soviet strain would have about the same risk of side effects, and side effects can be listed in two categories: minor side effects—sore arms and fever for the first 24 hours—and the major ones, which would included allergic reactions. We find that this happens only about once every 4 million influenza immunizations. The second major complication would be Guillain Barré Syndrome, and we find this happens about once every 105,000 immunizations, and about 5 percent of the people getting Eon Boray do, in fact, die, which means about 1 death per 2 million immunizations.

So, I think we are in a position of having a better idea of what the risks are and being able to compare this to influenza. For people who are in high-risk groups of influenza, the risk from disease is many times greater than the risk of death from Guillain Barré.

Senator HATHAWAY. Well, as far as allergic reactions, I suppose the individual knows whether he is going to be subject to that or not, but how about on the Guillain Barré Syndrome? Can you determine ahead of time whether that would be likely to happen in an individual?

Dr. FOEGE. We know of no way to screen out people for likelihood of Guillain Barré Syndrome. We do know that it is more likely to happen in the older age groups; that is also the age group most likely to have complications from the flu. But we know of no way to spe-

cifically look at an individual and make a decision on whether they would have a high risk of Guillain Barré.

Senator HATHAWAY. And is that from the vaccine itself, or is it just from the innoculation?

Dr. FOEGE. It is associated with people who get the vaccine. We really do not know the mechanism. We also do not know whether influenza itself carries a high risk of Guillain Barré, and this year we are hoping to do surveillance on what is the risk of Guillain Barré after natural influenza.

Senator HATHAWAY. What is the projected cost of this program?

Dr. FOEGE. If, in fact, we attempted to reach 20 percent of the high-risk group, we believe this would cost about $15 million during the current year.

Senator HATHAWAY. But then you said at the beginning that you are going to have a program that will be ongoing from year to year. So, will it be roughly the same or will it be increasing?

Dr. FOEGE. It would increase, and let me back up just a moment on those figures. The recommendation that has been made is that the Federal Government would assist the States, not pay for the entire program, and the $15 million would represent about two-thirds of the cost for reaching 40 percent of the high-risk group.

Senator HATHAWAY. Thank you all very much. I have some additional questions that I will submit to you in writing Senator Javits?

Senator JAVITS. Dr. Richmond, I will not keep you but 2 minutes, but I did have this question. I am naturally very much interested in what this bill does about the urban hospitals, especially the problem of the use of emergency rooms, et cetera, for clinic purposes. And I notice in reading your testimony that you are opposed to earmarking. We are not trying to earmark, but we are trying to raise the aggregate authorization. In addition, I see that you wish to await the determination of the President.

My problem with that is how much time do you want?

Dr. RICHMOND. Well, Senator, as the person who was the first director of the program that preceded what we now call community health centers—the neighborhood health center program was in the Office of Economic Opportunity, back in the 1960's—I share your concern about movement. I can assure you that we are in the process of planning. We have certainly been communicating with people on your staff concerning the matter of extending community health services in the urban setting.

We do hope that the President, as part of the overall urban initiative of his administration, will be persuaded that we have got to move quite rapidly. But we certainly are essentially in agreement with the principles that you and your staff have enunciated in terms of directions in which we ought to go.

Senator JAVITS. Well, how very kind of you, and it is terribly helpful. So you feel the President's views will come within the total of what he offers to the urban community?

Dr. RICHMOND. Yes.

Senator JAVITS. Well, all I can say in response to that is that I am not committed to waiting, but will certainly give a modest opportunity to see what the President comes up with. I am going to write

the President and urge him to include this proposal in his urban initiative.

The other question I would like to ask you is a question raised by Dr. Davis. He raised the point about the fact that in my bill, we allow construction, whereas in the community health centers, we only allow for renovation, and he asked why. Can you tell me if you believe we would need construction authority to accomplish these program's objectives?

Dr. RICHMOND. Well, I think, Senator, that as we move into the greater expansion of services, it probably will be necessary to have some construction funds. While we realize this does consume rather large amounts, nonetheless for some of the reasons Dr. Davis indicates—that is, the need to have physicians and other health providers working in appropriate kinds of settings—we think that some new construction would become necessary.

Senator JAVITS. My reason for including it was that the difficulty with emergency room use was that it was in hospitals. If you are going to have some kind of a clinic and you are going to avoid clogging the emergency facility, you have to put it somewhere. You might put it in the same hospital, but it would still be construction, not a renovation.

But I promise you, Dr. Davis, because I very much support the community health centers—I promise you that we will do our utmost to see that there is no undue expenditure on bricks and mortar which would take money away from anybody. The idea is to really separate the clinical facility from the emergency facility, so that the emergency facility can do its job.

The last thing I would like to say is that I thank you very much, Dr. Richmond, for your support of the extension of the genetic diseases bill for 3 years, and we will proceed with that with considerable encouragement, now that you have felt that that is the right way to go. If we have any other questions, I will submit them to you in writing.

Dr. RICHMOND. Thank you very much.

[The prepared statement of Dr. Richmond and his responses to written questions submitted by the subcommittee follow:]

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

STATEMENT

BY

JULIUS B. RICHMOND, M.D.

ASSISTANT SECRETARY FOR HEALTH

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

BEFORE THE

COMMITTEE ON HUMAN RESOURCES

SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH

UNITED STATES SENATE

THURSDAY, FEBRUARY 9, 1978

MR. CHAIRMAN, MEMBERS OF THE SUBCOMMITTEE:

I am pleased to be here again today. This morning your hearing concerns statutory authorities for Federal programs providing health services and disease prevention and control.

These programs include the community health centers, migrant health centers, comprehensive public health grants to States, hypertension, immunization, venereal disease, and other disease control programs.

For the most part, they are administered in two agencies of the Public Health Service: the Health Services Administration, and the Center for Disease Control. Accordingly, I am accompanied this morning by Dr. George Lythcott and Dr. William Foege, respective Administrator and Director of those two agencies. In addition, I am accompanied by Dr. Joyce Lashof, Deputy Assistant Secretary for Health-Programs, and Dr. Karen Davis, Deputy Assistant Secretary for Planning and Evaluation/Health.

In my prepared statement, I will briefly describe the current status and achievements of, and legislative proposals for, our service delivery, capacity building, and public health prevention and disease control activities. Following that, my colleagues and I will be happy to respond to your questions.

As the members of this Subcommittee know, these service delivery and disease prevention programs provide us with some of our most direct Federal links to the everyday health care problems of individuals. Due in large measure to the compassionate leadership of your Subcommittee, Mr. Chairman, their accomplishments can be measured by the improved quality of health for the populations in greatest need.

Capacity Building Programs

I would like first to discuss our capacity building programs. Our Federally funded primary care programs include Community Health Centers, Migrant Health, Healty Underserved Rural Areas, Maternal and Infant care, and Children and Youth programs.

As of 1977, a total of 5.7 million persons were being reached through the HSA capacity building programs. This represents an increase of over 75 percent since 1975. Eighty percent of these people are poor. Eighty-five percent of them are members of minority groups.

However, these programs do not fill the needs of all underserved areas, Mr. Chairman. An estimated 45 million Americans live in approximately 7200 medically underserved areas; 56 percent of these persons are in rural areas and 44 percent are in urban areas.

Between 1975 and 1977 HSA established a total of 350 new centers, increasing access to services for 2.5 million persons. During 1977 alone, we established a total of 200 new centers providing access to approximately 1.25 million residents of medically underserved areas and health manpower shortage areas.

Of the 836 health services grantees, 520 are in rural areas and 316 are in urban areas. Based on the 1978 appropriations and our requests for 1979, we hope to develop 150 additional community health centers this year and 131 in 1979.

These centers are located in areas of medical underservice, characterized by above-average poverty and infant mortality rates, higher than average proportions of the aging and a shortage of physicians and other providers.

They have focused on preventive health measures, substituting less expensive ambulatory care for more costly, sometimes unnecessary hospitalization.

During a relatively short life span, the capacity building efforts have demonstrated their flexibility in providing health care which integrates health services, health and nutrition education, social services, mental health counseling and environmental services into a more efficient and cost-effective delivery system.

These programs have proved successful in improving health status and health services distribution at reasonable costs.

A nationwide study showed that health center users experienced 24 percent less hospitalization than those in the same income category among the general population.

We will propose three-year extensions for the community health center and migrant health programs, Mr. Chairman, at an authorization level of $301 million for community health centers and $34.5 million for migrant health for fiscal 1979, and such sums as may be necessary for the following two years.

In addition, I should note that our recent efforts to improve the administration and management of these centers have generated considerable savings. Administrative costs have gone from 25 percent to 20 percent of the cost of the program, resulting in increased spending for patient care. Moreover, collection of third-party reimbursement has risen from 17 percent of total costs in 1974 to 36 percent in 1977.

Over the past three years, we have more than doubled the numbers of patients served (from 1.4 million to 3.4 million between 1975 and 1977) with a relatively small increase in appropriations (from $197 million to $215 million). The cost of a comprehensive visit is now often significantly less than a visit to an outpatient department or emergency room.

The objective of maximizing third-party reimbursement has further sharpened the business management, billing, and administrative skills of the centers.

Closely linked to our capacity building programs is the National Health Service Corps, which will provide significant staffing as we expand the number of centers.

The NHSC Scholarship Program assignees as well as other Corps recruits will also provide health services in manpower shortage areas to patients in a variety of settings. Those include public health facilities, State mental hospitals and Indian Health Service facilities. We are using NHSC personnel, including nutritionists, public health nurses, and medical social workers, on assignment with local and district health departments to assist them in planning and carrying out programs.

Up to this time we have emphasized rural settings in our assignment of Corps personnel. Now a greater emphasis on urban projects will complement our long-range intentions to meet manpower requirements in all areas of great need. We support the provision in your bill mandating a report of NHSC manpower projections, and present and future directions. We believe we can meet the deadline specified in that provision.

For the National Health Service Corps we request an increase in the 1979 authorization from $57 million to $64 million to accommodate the number of Corps personnel who will be available for assignment in fiscal year 1979. The existing authorization level for fiscal year 1980 is considered adequate for an anticipated field strength of up to 3,000.

Before I move on to the discussion of our disease control and prevention activities, I would like to speak to the urban health care problem addressed in section 106 of your bill, Mr. Chairman. In particular, you address the need to enhance the ability of urban hospitals in underserved areas to provide comprehensive primary care services.

As you know, the poor in these underserved areas often use the hospital outpatient department and emergency room for the delivery of primary care rather than for the specialized services for which they were designed. Not only has this resulted in many individuals not receiving appropriate primary care services, but it has also contributed to the generation of huge deficits in these hospitals.

Mr. Chairman, we support the conceptual basis of your proposal, because we believe the community health center program provides the flexibility necessary to relate the hospital setting. Your approach would greatly enhance our capacity to demonstrate more effective ways to deliver comprehensive primary services to the inner city poor and provide a degree of fiscal relief to these hospitals. However, the Administration is still considering an urban initiative in health, and we would thus be opposed to any additional specific earmarking in current programs. We believe there are sufficient funds to begin to work with the urban hospitals in 1979; however, we must await the President's decision before commenting on the higher authorization level proposed in your bill.

Several other legislative authorities are under consideration: The Bureau of Community Health Services administers home health grants to public or nonprofit private organizations to: (1) meet the initial costs of establishing and operating a home health agency in areas where such services are not otherwise available, (2) expand services provided by existing home health agencies, and (3) meet the costs of compensating professional and paraprofessional personnel during the initial operation of such agencies or the expansion of such services through existing agencies. In 1976 and 1977

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we developed 30 new home health agencies and assisted in the expansion of 82 existing sites, providing home health services to over 30,000 persons. In 1978 and 1979 we plan to expand the program by 40 new developmental grants and 20 training grants.

Assistance is provided to the States under section 314(d) for the screening, detection, diagnosis, prevention and referral for the treatment of hypertension; currently all States have operative programs. We will propose the extension of this program for three years to strengthen the efforts of the States in follow-up for treatment. We also propose a three-year extension of the hemophilia program, which awards grants for comprehensive hemophilia diagnostic and treatment centers to provide services, train professional and paraprofessional personnel in hemophilia diagnosis, research, and treatment, and to offer social and vocational counseling for hemopiliacs and their families.

We are proposing a three-year extension of the Genetic Diseases authorities, which includes sickle cell anemia, Cooley's anemia, Tay-Sachs disease, cystic fibrosis, dysautonomia, hemophilia, retinitis pigmentosa, Huntington's chorea, and muscular dystrophy. We estimate that six percent of the population suffers from severe genetic disease; our studies indicate

that about 30 percent of hospitalized children have diseases of genetic origin, 40 percent of all infant mortality results from genetic factors and that up to 80 percent of mental retardation due to medical organic causes is genetically related.

While time is not available to dwell on the accomplishments of these programs, I wish to underscore our belief in their importance.

I would like to make just one final comment regarding the importance of these programs in meeting the needs of special initiatives underway to improve immunization levels and

adolescent health. We expect the Bureau of Community Health Services programs to be a major delivery resource for improving family planning services, maternal and child health programs, and increasing immunization rates. We also anticipate providing necessary services for the CHAP program when it is enacted by the Congress.

DISEASE PREVENTION AND CONTROL

I would now like to address the area of disease prevention and control. As you know, Mr. Chairman, this Administration is committed to incorporating prevention as the heart of a comprehensive strategy for improving the health of the American people. Both Secretary Califano and I are committed to bringing more knowledge to the area of prevention and at the same time applying most effectively what we do know. Perhaps nowhere is this challenge better evidenced than in our community prevention programs, which are charged with carrying out outreach, epidemiologic assessment, surveillance, community organization and health education, and ensuring that high-risk population groups receive appropriate preventive services. We are determined to creatively structure the most effective and responsible delivery of these services.

I believe it would be useful to cite certain accomplishments which merit mention.

-- Immunization

Late in fiscal year 1977, Secretary Califano announced the implementation of a program to raise immunization levels of the Nation's children under age 15 from 60 percent to 90 percent, and to establish an effective, ongoing system to provide appropriate, comprehensive immunization services to the approximately 3 million children born in America each year. Major progress has already been made in heightening public awareness of our children's immunization needs, and in galvanizing the resources and energies of government agencies and volunteer groups into a unified program to achieve these goals. Procedures have been established for the systematic identification of incompletely immunized pre-school and school age children. Remedial action programs are underway to provide appropriate immunizations to those children. These efforts are accomplishing results, as evidenced by the significant increases in the number of doses of vaccine administered in public programs during the last three months of 1977 compared with the same period in 1976. The gains in doses of vaccine administered nationwide were 40 percent for measles vaccine, 34 percent for rubella, 42 percent for polio, 91 percent for mumps, and 38 percent for diphtheria-tetanus-pertussis.

-- Venereal Disease Control

We are also seeing impressive signs that the cooperative national effort to control venereal disease is producing favorable results. In fiscal year 1977, the number of reported cases of gonorrhea declined very slightly--this marks the first time in almost 20 years that we have not witnessed an increase in gonorrhea. This slight decrease occurred in concert with a continuation of intensive casefinding activities. Over 8.5 million women were tested for gonorrhea through our screening programs, of whom 394,000 were found to be positive.

In early 1976, cases of gonorrhea caused by a new strain of gonococcus resistant to penicillin suddenly emerged in the United States and England. To meet the threat of importation and spread of this new strain for which the standard treatment of choice is ineffective, the Center for Disease Control, working closely with State and military health authorities, rapidly developed and implemented an intensive control strategy which has contributed to the containment of this organism to date.

For the second consecutive year, and into the first quarter of fiscal year 1978, we have seen a decline in the number of reported cases of infectious syphilis. Again, this

reflects the greatly intensified case detection and prevention measures carried out by State and local health departments with grant support and national leadership from CDC. The downward trend holds true for all stages of syphilis as well, including congenital syphilis among children, which decreased by more than 11 percent in fiscal year 1977.

-- Lead-Based Paint Poisoning

As you are well aware, Mr. Chairman, childhood lead poisoning has long been recognized as a health problem which can result in serious behavioral disorders and even death. Once considered a problem primarily of the inner part of large cities in the so-called "lead belt" of the Northeast, the lead hazard is now known to be endangering children in all sections of the country--North and South, East and West, and in rural as well as urban environments.

In fiscal year 1977, 58 grant supported local programs screened some 380,500 children, of whom more than 28,000 were found to need pediatric followup. At least 95 percent of these children are receiving the necessary pediatric management services to completion, and the lead hazard has been abated in 61 percent of their houses. We estimate that 65 grant supported programs will test 500,000 children in fiscal year 1978, 42,500 of whom will be identified with undue lead absorption.

The childhood lead poisoning prevention grant program has been instrumental in the rapid dissemination and broad applications of technological innovations, such as the hematoflourometer, which allows a child to be tested on site, provides a screening test result in four seconds, requires no chemical manipulations, and costs less than 10 cents per test in consumable supplies. Furthermore, a normal test rules out not only lead poisoning, but iron deficiency as well.

-- Rat Control

By the end of fiscal year 1978, as a result of grant supported programs, an estimated 6 million Americans will be residing in communities which have been rendered essentially free of rats. Over 23,500 residential blocks will no longer require intensive rat reduction activities. The maintenance activities required for those blocks can be totally supported with local resources, thus freeing up Federal grant funds to be applied in new target areas. In conjunction with funding from other Federal sources such as CETA, these grant funds currently provide employment for approximately 2,000 individuals, of whom over 60 percent are residents of the program target area.

Your Subcommittee currently has a bill under consideration which proposes a one-year extension of disease control and prevention authorities, Mr. Chairman. While we would be opposed to enacting a simple one-year extension of these authorities at this time, it is our understanding that the legislation was introduced in its present form primarily to give you time to develop a more comprehensive prevention initiative later this spring.

We understand you are in the process of consulting with interested outside groups and that you will be proposing legislation in the near future. Accordingly, rather than commenting further on the one-year extension, I will outline our own prevention proposals, and express the hope that we can work closely together in this vital health care area.

We will soon be submitting legislation to you, Mr. Chairman, proposing a consolidation of existing disease prevention and control programs into a single annual grant to States. This comprehensive grant will consolidate existing authorities for disease control, lead-based paint poisoning, venereal disease, rat control, immunization, and the comprehensive public health services grant to States (section 314(d)), except for hypertension and mental health planning. We believe that States should be assisted in meeting the cost of providing required disease control and prevention programs of high national priority. We would expect to require States to specifically earmark a portion of their grant for childhood immunization activities.

With regard to other disease prevention and control activities, however, States must be given sufficient flexibility so that they can determine which priority problems should be addressed with these Federal funds.

While States will thus be afforded considerable flexibility to set their own prevention spending priorities for the Federal dollars they receive, flexibility will have to be balanced with the need for accountability. In order to achieve such a balance, we will recommend that State health planning activities under P.L. 93-641, and in particular the requirement for development of a coordinated State health plan, address the extent of the need for preventive health programs and services, and that States submit plans to spend the money they would receive from this program in accordance with needs identified in those plans. The Secretary would approve the plan prior to allocating these funds. We also favor incorporating audit and reporting mechanisms so that the Congress and the Secretary can review and examine whether funds are spent for appropriate preventive services identified in the State's plan and approved application.

Incorporating the section 314(d) authorities into this comprehensive State grant would allow States to continue to spend that money on needed preventive health activities. It recognizes that certain of those traditional activities may require Federal funding in some States but not in others.

I want to emphasize that we are looking forward to working closely with this Subcommittee in further refinement of this legislation.

Thank you for the opportunity to testify on these vital health care delivery and prevention issues today. We have attached a table including the Administration's proposed authorization levels for fiscal year 1979. We will shortly be submitting extension legislation. My colleagues and I welcome any questions you may have.

Senator Kennedy - Community Health Centers - Question No. 1

The Administration's budget proposes to increase funding for Community Health Centers from $247 million to $301 million. Given the fact that these programs now reach 9.5 percent of the 45 million people living in medically underserved areas, why are you requesting so little additional funding?

Answer:

Approximately 49 million people currently reside in medically underserved areas. While Community Health Centers are serving an estimated 3.7 million or 7.5 percent of these people, an additional 2.5 million persons who reside in these areas are served by other projects (Migrant, Health Underserved Rural Areas, etc.). Therefore, approximately 12.6 percent of the residents of medically underserved areas will be served by Bureau projects this year.

Program emphasis over the past year has been on consolidating and integrating the resources of all Bureau programs so that we can more effectively meet the health needs of the maximum population with the minimum resources. The FY 1979 budget request would allow us to continue and strengthen this approach. The projected number of people to be served by Community Health Centers in FY 1979 is 4.2 million or 4.7 million when the President's Urban Initiative is included. This latter figure represents almost 10 percent of the residents of medically underserved areas. This amount of growth is in consonance with Departmental priorities and current budget constraints.

Senator Kennedy - Community Health Centers - Question No. 2

2. Since 1975 the cost per patient served by Community Health Centers has dropped by 50 percent. This is truly remarkable at a time when double-digit inflation has characterized the cost of health care services in other sectors. What part of this reduction in cost can be attributed to increased administrative efficiency, and what part results from the fact that of the 574 centers established, only 158 are providing comprehensive services--with the remaining 416 providing little more than the presence of a physician or physician extender and a very limited range of services.

Answer:

The 50 percent reduction in the cost per patient served by Community Health Centers can be attributed to two factors--increased efficiency among the ongoing centers (those operational more than 2 years) and modified funding strategy for new centers. The 574 centers estimated for fiscal year 1978 can be distributed among the following categories: 158 ongoing CHCs, 356 Rural Health Initiative centers (RHIs) and 60 Urban Health Initiative centers (UHIs). For the ongoing CHC, increased efficiency has been accomplished primarily by reducing administrative overhead costs and increasing physician and other provider productivity. Between 1975 and 1977, ongoing CHCs have shown a relative reduction of 10 percent in their administrative costs while having a 13 percent relative increase in their provider productivity. The end result of this increased efficiency is service being provided to more people in the ongoing CHCs. These savings have been used to assist in initial funding of RHI and UHI projects.

With the funding of centers under the RHI and UHI, the PHS embarked upon a funding strategy that encouraged an incremental approach to the development of new centers. This approach emphasized the establishment of centers that initially would provide only primary ambulatory health services (including preventive health and preventive dental services). After the primary services are in place, then the centers will expand to provide more comprehensive health services. By the end of fiscal year 1977, all but about 13 percent of these newly funded centers were providing or were prepared to provide the required primary health services.

Senator Kennedy - Community Health Centers - Question No. 3

3. What percentage of the community health centers and migrant health projects meet the governing board requirements spelled out in sections 319 and 330? Under what circumstances and authority does HEW grant waivers of the governing board requirements? Of the centers funded as rural or urban health initiatives (RHI/UHI), what percentage have governing boards?

Answer:

In fiscal year 1977, a total of 455 community health centers (CHC) grants were funded. Of this number, 85.5 percent (389 projects) meet the governing board requirements spelled out in section 330 as the following table indicates. Of the 66 projects not meeting the governing board requirements, 8 CHC projects are in the process of meeting the governing board requirements during fiscal year 1978, 45 (43 RHIs and 2 UHIs) are planning and developing projects which will meet the governing board requirements once they become fully operational and the remaining 13 projects (7 RHIs and 6 UHIs) will be in compliance with the governing board requirements within the next 2 years. The statute and the regulations stipulate that entities which do not meet the governing board requirements may be awarded up to 2 operational grants (2 years) to develop compliance with all CHC requirements.

Section 330 Grants		Meeting Governing Board Requirements	Not Meeting Governing Board Requirements
Total	455	389	66
CHCs	158	150	8
RHIs	262	212	50
Planning & Devel.	(43)	(0)	(43)
Operational	(219)	(212)	(7)
UHIs	35	27	8
Planning & Devel.	(2)	(0)	(2)
Operational	(33)	(27)	(6)

In fiscal year 1977, the migrant health centers program funded 102 service delivery grants. Of these, 70 percent are operational migrant health centers which meet the governing board requirements. The remaining 30 percent of the service delivery grants are operational migrant health projects which are not required to meet the governing board requirements.

Senator Kennedy - Community Health Centers - Question No. 4

4. What procedure does HEW follow at present when a Community Health Center is run by a public agency which, under State law, cannot have its programs determined by a consumer governing board. In how many instances has this been a problem, and how has it been resolved?

Answer:

There is nothing in our current regulations which prohibits State or local governments from becoming community health center grantees. Experience with the program since enactment of P.L. 94-63 has indicated that the requirement that the applicant for community health center grant funds establish a consumer majority governing board with the authorities specified in law may unduly restrict the ability of some public agencies to apply for center grants. The regulations were revised on November 25, 1977 (Federal Register, Volume 42, No. 227) to permit joint applications, where, for example, a public agency itself may not be able to meet the definition of a community health center but the entity sponsored by the public agency to provide the services may, in fact, meet the governing board requirements. This change in the community health center's regulations allows public entities to become co-applicants and avoid delegating their statutory responsibilities to another entity. There are currently 109 grantees under section 330 that are public agencies, county health departments, hospitals or medical schools, and 101 of these projects have met and 8 of these projects are in the process of meeting the governing board requirements. (8 of these projects are planning and developmental projects.)

We have no way of knowing how many public entities have in the past been discouraged from applying for grants because of the governing board requirement.

Senator Kennedy - Community Health Centers - Question No. 5

5. Your figures show an average reimbursement rate of 30 percent from third parties for services provided through Community Health Centers. How much of this percentage comes from (1) Medicaid, (2) Medicare, and (3) the patients themselves? Is it realistic to expect such payments to increase substantially in the coming years?

Answer:

Our FY 1977 reimbursement rate for Community Health Centers is 31 percent ($114,992,896) of the total operating costs. Of this amount 17 percent ($63,060,622) is from Medicaid; 3 percent ($11,128,344) from Medicare; 9 percent ($33,385,034) from patients and 2 percent ($7,418,896) from other sources. We have been providing extensive technical assistance to projects in developing and improving their project and billing and collection systems. Our current estimates for FY 1978 and FY 1979 of 35 percent and 36 percent respectively are based on expected improvement in project management and the revised Bureau's Common Reporting Requirements which focus attention on the revenue and accounts receivable reports. This will lower total operating costs and, corespondingly, collections will represent a relatively higher percent of operating costs. We have also worked extensively with Medicaid and Medicare programs in clarifying reimbursement issues related to federally funded projects. These efforts have helped centers to not only deal effectively with current financial entitlement programs but also to gain experience to take advantage of new entitlements as they become available. These activities and reimbursement program changes such as the passage of P.L. 95-210 for the reimbursement of rural clinic health services are also expected to increase reimbursements to centers. Beyond FY 1979 there is no projection for increased reimbursements. We feel that the maximum collection is 36 percent of total operating costs from the third parties. We believe that an increase much beyond 36 percent would only be realized after major changes in health services financing or reimbursement authorities in the United States.

Senator Kennedy - Community Health Centers - Question No. 6

6. Legislation has been introduced in the House to require HEW to base funding for Community Health Centers on the amount by which a Center's projected cost of operation exceeds its projected receipts from third party reimbursements and state, local and other funds. How does this differ from the way such funding is determined now? How much additional budget authority would be needed to fulfill this requirement if it were enacted into law?

Answer:

This proposed legislation does not differ from current HEW funding policy. In addition, Community Health Service regulations provide that the Secretary will consider the following factors in determining the percentage of project costs to be borne by the grantee:

a. The ability of the grantee to finance its share of project costs from non-Federal sources;

b. the need in the area for the services provided by the project;

c. the extent to which the project will provide services in an innovative manner to further develop effective health service delivery systems in medically underserved areas.

Therefore, no additional funds are required.

enator Kennedy - Community Health Centers - Question No. 7

1. As you may know, S. 133, the new Americans Health Service Act introduced by Senators Inouye and Matsunaga is also pending before our subcommittee. To what extent are existing health centers reaching immigrants and have you considered the establishment of special health centers designed to meet their needs in the six states in which they are concentrated?

Answer:

Under existing legislative authority, the Bureau of Community Health Services makes available a wide range of health services. During 1977 a total of 455 Community Health Centers provided health care services to 3.4 million persons and 102 Migrant Health projects served 499,000 migrants and seasonal farmworkers and their families. The former program focuses on medically underserved populations in both urban and rural areas while the latter is specifically mandated to provide access to services for a specific population group. We believe that a number of these projects are addressing the health needs of immigrant groups. In cases where the immigrants are unable to pay for services but meet the eligibility criteria, Medicaid is available for financing the services.

The Department, in FY 1978, plans to investigate the health care needs of immigrants in the ten States with the highest proportion of immigrants to the total population. The Department expects to develop and fund three to four projects in these high priority areas during FY 1978, using available funding under Section 330 of the Public Health Service Act. Based on its experience with this assessment and the development of additional projects the Department will report to Congress and make recommendations for future action.

Senator Kennedy - Community Health Centers - Question No. 8

In the Conference report which accompanied the fiscal year 1978 appropriation for the Department of Health, Education and Welfare the Conferees stated their position that, beginning in fiscal year 1979, no further Medicaid funds would be provided to begin new projects under the Health Underserved Rural Areas (HURA) program. The Conferees further stated: "In future years rural health activities of this type are to be funded under the community health centers authority of the Public Health Service Act where there is already an ongoing rural health initiative." What steps has the Department taken to assure that, as a result of this directive, there is not a $15 million shortfall in this area and what recommendations can you make to the Subcommittee as to how this problem should be addressed?

Answer:

The Conference Report directed that fiscal year 1978 be the last year in which new starts be made under the HURA program as authorized under the Medicaid program and that in future years activities of this type are to be funded under the Community Health Center authority, Section 330 of the Public Health Service Act.

The Department has included $15 million in its fiscal year 1979 budget request to continue the HURA program. This request has been made under the Community Health Centers Program based on the research and demonstration authority of Section 1110 of the Social Security Act, pending passage of a separate authority. The Department has also proposed that a new section be added to the Public Health Service Act to establish a statutory authority for this program. This proposal requests authorization of $15 million for fiscal year 1979 and such sums as may be necessary for two subsequent years.

Senator Kennedy - Migrant Health Programs - Question No. 1

1. The Congress has provided separate legislative authority for the Community Health Center Program and the Migrant Health Center Program. It is my understanding that there is good coordination between the two programs and that they are even administered out of the same suite of offices. In the three year extension you are requesting for these programs do you see any need to change the present legislative framework for these programs? Isn't it true that the difference in the two programs are differences specifically designed to meet the special cultural and health needs of the migrant population?

Answer:

It is true that there is good coordination between these two programs. Coordination and services integration are key components of the capacity building strategy which relates resources of several Bureau programs to more effectively address the problems of medical underservice through coordinated sites and services in both rural and urban areas. We expect this type of program sharing to continue and would not, therefore, see any need to change the present legislative framework for these programs. The differences in the two programs are indeed specifically designed to meet the special cultural and health needs of the migrant population. It is because of the cultural and related barriers that such a separate legislative authority is useful. For the foreseeable future we would expect the need for this legislatively based advocacy role to continue.

Senator Kennedy - Migrant Health Programs - Question No. 2

2. The administration has requested a 20 percent increase in funding for Community Health Centers. No increase at all has been requested for Migrant Health Programs. How was this decision reached? What will this mean to the 80 percent of the migrant and seasonal work force which does not now have access to migrant health programs?

Answer :

The Department is faced with the problem of making hard choices during a time of fiscal constraint. The approach has been to maintain the Migrant Health Program at its 1978 level while finding effective alternative ways of providing services to migrants. The Migrant Health Program is an integral part of the Bureau's capacity building strategy to address problems of medical underservice in areas of greatest need. Through this effort, a portion of the resources of the Migrant Program is linked with those of other Bureau Programs (Community Health Centers, National Health Service Corps, etc.) so that increased access to comprehensive services is provided to migrants and seasonal farmworkers and their dependents through a larger number of access points being developed throughout rural areas.

In addition to these integrated relationships, the Migrant Health Program is also affiliated with other federally-supported programs which have authority to provide services for migrants. Thirty-four projects have referral or staff affiliation with community mental health centers through a joint agreement with the Alcohol Drug Abuse and Mental Health Administration (ADAMHA), 48 migrant projects serve as grantees or referral points for services under the Department of Agriculture's Women, Infants and Children (WIC) Nutrition Program, and 47 migrant projects are affiliated with State Title I Migrant Education Program which provides summer educational and supplemental services to migrant school children. It is expected that these types of linkages will improve the scope of services provided and increase capacity to provide services to migrants.

Senator Kennedy - Migrant Health Centers - Question No. 3

3. The Department of Labor has funds available for migrant health in connection with its employment and training programs. It is my understanding that in Delaware, Maryland, and Virginia, for example, there is no coordination and that the Department of Labor programs in those States have more money for migrant health than HEW sponsored programs. How are your efforts coordinated with those of the Labor Department?

Answer:

At the present time, coordination between HEW's and the Department of Labor's health service efforts is accomplished primarily at the project level. Approximately 60 HEW migrant health projects have arrangements with Department of Labor CETA projects to provide job positions and training opportunities for CETA enrollees.

In order to more effectively utilize the health related resources of both agencies, we are initiating contact about development of an interagency agreement which would encourage or require increased cooperation at the project level. We will provide a report of progress to the Committee by July 1, 1978.

Senator Kennedy - Migrant Health Centers - Question No. 4

In response to a question from Senator Hathaway concerning the adequacy of current funding for hospitalization of migrants, you testified that the Administration intends to submit legislation to resolve Medicaid residency requirements which have stood in the way of migrants requiring hospitalization. When will this legislation be sent to the Congress? What assurance do you have that the Finance and Ways and Means Committees would be able to complete action on this major change in Medicaid legislation before the end of the 95th Congress?

Answer:

The proposal to deal with the Medicaid "intent to reside" problem has been forwarded to the House Commerce Committee, at their request, and has been incorporated as an amendment by that Committee to H.R. 13611, the Administration's Child Health Assessment Act. We fully anticipate final House and Senate action on this amendment in the current session.

Senator Kennedy-Comprehensive Public Health Services (314(d))-Question No. 1

You are aware of the Association of State and Territorial Health Officials' proposal to modify 314(d) from a formula grant program to a cost-sharing, Federal entitlement prorgram? What is your position on tis proposal?

Answer:

(1) The Department's position on 314(d) is that it should be combined with current activities relatd to rat control, lead based paint, tuberculosis, venereal disease and immunization and formed into a new grant to States required to be focused on preventive health activities.

(2) The Department is opposed to the Association of State and Territorial Health Officials' proposal to modify 314(d). In addition to budgetary concerns with the authorization levels it sets for a modified section 314(d), we question that aspect of the ASTHO proposal which would eliminate the financial need factor in the current statute whereby States with a lower per capita income receive a proportionately higher allotment.

Senator Kennedy - Comprehensive Public Health Services (314(d)) - Question No. 2

2. What specific State public health programs do you see benefiting from such increased Federal matching funds? How much of the monies go into the support of State laboratories and general public health activities?

Answer

The programs, projects, or activities which are supported with funds under section 314(d) are determined by each State, reflecting its own needs, priorities, and goals. An increase in funds is likely to be used to support those services which have the highest priority in each State. The State Health Coordinating Committee must be given an opportunity to review and approve or disapprove an application for these funds and the Health Systems Agencies must have an opportunity to approve or disapprove the use of the funds within their planning areas.

The Public Health Reporting Systems showed that in fiscal year 1975 the State health agencies expended $12,744,000 of section 314(d) funds for State laboratories, $7,387,000 to administration, and $53,008,000 was expended on all other activities.

Senator Kennedy - Comprehensive Public Health Services (314(d)) - Question No. 3

3. Have the monies provided over the last three years through section 314(d) been used in a way that makes further expansion of the program immediately desirable?

Answer

The monies provided under section 314(d) over the last years have been used in accord with the legislation and the apparent intent to broadly support comprehensive public health services. Except for that portion of the funds used to support State institutions operated by the State health agencies, the 314(d) funds, in the aggregate, supported a wide range of personal health services, environmental health services, health resources development, State laboratories, and general health administration. The Department has not recommended an increase in the section 314(d) authorization. Increased support of capacity building programs specifically directed to medically underserved areas is expected to have a more immediate impact on health problems in areas of identified need.

Senator Kennedy - Comprehensive Public Health Services (314(d) - Question No. 4

4. Do you expect the voluntary ASTHO reporting program to meet your data needs in this area?

Answer:

The Association of State and Territorial Health Officials' reporting program has sufficient flexibility to provide a description of the comprehensive public health services in each State, as required under section 314(d). We hope to advance the reporting to be able to have data summarized more promptly following each fiscal year and to allow the State agencies to prepare for data collection in advance of each fiscal year. We also plan to obtain more detailed reporting from local health departments. Our expectation is that the ASTHO Reporting System will meet our needs.

It is the Department's intent in combining 314(d) programs into a preventive health initiative to focus a greater emphasis on Federal direction and management of this activity. Again, we believe the ASTHO system can be tailored and be useful for meeting these needs.

Senator Kennedy - Prevention and Public Health Services

1. Are you suggesting that the Administration will introduce legislation to consolidate a number of the present categorical disease control programs into one program.

   -- How would you propose under such a consolidation to assure an ability to target funds toward national priorities?

   Answer

   Under our proposal the State would be required to submit a State plan for approval by the Secretary in advance of receipt of any funds. The State would be required to address high priority national programs specifically in the plan.

   -- How would you propose to set national priorities?

   Answer

   The establishment of national priorities would be based on the extent of the problems caused by the disease or adverse health conditions, and on the availability of effective means of preventing or ameliorating them.

   -- What would be the Federal role and responsibility under such a consolidation? Does the Federal level retain funds for special priorities?

   Answer

   It would be the responsibility of the Federal Government to: (1) establish national priorities; (2) require that these be addressed in the State plan in advance of funding; this State plan could be disapproved in whole or in part; (3) establish a list of optional preventive programs for which States could use those funds not required to meet national priorities; and (4) monitor and audit both expenditures and program accomplishments.

   The Federal Government would retain up to 20 percent of any additional funds appropriated for the initiation of new programs or for demonstrations to develop and evaluate methodologies to apply to other diseases or conditions.

Page 2 - Senator Kennedy - Prevention and Public Health Services

-- Do you see any problems with assuring accountability for expenditure of funds? Recall that under the block grant under 314(D) for many years we had no information on how the funds were being spent. There was no accountability. How under a new block grant approach would you assure accountability?

Answer

We believe that with the State plan requirements in our proposal that we will be able to assure accountability. The plan would have to address Federal priorities; it would also have to address optional preventive health programs. The Secretary would have the authority to approve the plan in whole or in part, and finally the States would be required to report both expenditures and program accomplishments on a yearly basis.

-- Would you be willing to work with us in developing a more comprehensive approach to authority for preventive health?

Answer

We would be delighted to work with the Subcommittee, as well as with other interested parties in developing a comprehensive strategy for prevention. We are anxious to obtain the broadest possible range of viewpoints and expertise, including those of State and local government, the medical community, the Academic community, and the Congress.

Responses to Senator Kennedy's Questions re: IMMUNIZATION PROGRAMS

1. We hear a lot about the target of 90% levels of immunization. How did that target get established? Should the target be the same for each of the diseases against which we are immunizing. How many years will it take to achieve that target? How much will it cost in 1980 and 1891 to maintain it. What immediate impact should we expect on the health of American children?

QUESTION: How did that target get established?

ANSWER: A number of factors were considered in establishing the 90 percent immunization level target: (1) The higher the level of immunizations, the less significant is the public health problem posed by a disease. (2) A 90 percent immunization level is achievable. After polio vaccine first became available and the threat of annual polio epidemics was percent, immunization levels against polio approached 90 percent (3) Immunizations in excess of 90 percent would be very difficult if not impossible to achieve. (4) An immunization level of 80 percent or lower is unacceptable.

A 90 percent immunization level is a high goal and one which will be difficult to reach. It is based on a projected level of Federal support, enthusiastic support of State and local health agencies and volunteers, and hard work.

QUESTION: Should the target be the same for each of the diseases against which we are immunizing?

ANSWER: As mentioned above, an immunization level of 90 percent is one which is desirable and which we believe can be reached. The age group included in the target varies by antigen and is based on the Advisory Committee on Immunization Practices (ACIP), recommendations. For example, the target for polio includes children age three months to 14 years. For rubella the target includes children over age one through 12 years. For mumps, because of difficulty in determining susceptibles in the school-age population and the high cost of mumps vaccine, we feel the goal of 90 percent should apply only to the preschool-age population. The inclusion of mumps vaccine for school-age children would increase cost by more than $20 million.

QUESTION: How many years will it take to achieve that target?

ANSWER: Original estimates were that an average immunization level of 90 percent could be reached by October 1979. These estimates were based on the assumption that projected funding would be available at the beginning of fiscal year 1978. It has not been determined whether or not delays in receiving the 1978 projected funding appropriation (October to December) will significantly delay our attainment of that goal.

QUESTION: How much will it cost in 1980 and 1981 to maintain it?

ANSWER: The Secretary's immunization initiative includes as one of its goals, the establishment of a continuing program which is capable of providing immunization against measles, rubella, polio, mumps, diptheria, pertussis, and tetanus to all children entering the population. The annual cost of this program is estimated to be $18.5 million.

QUESTION: What immediate impact should we expect on the health of American children?

ANSWER: We have established the following as health targets:

1. Measles - quarterly incidence in FY 1978 will be 33 percent lower than in comparable quarter FY 1977.
lower than in comparable quarter FY 1977.

2. Rubella - quarterly incidence in FY 1979 will be 25 percent lower than in comparable quarter FY 1977.

   - quarterly incidence in FY 1979 will be 33 percent lower than in comparable quarter FY 1978.

3. Mumps - quarterly incidence in FY 1978 will be 25 percent lower than in comparable quarter FY 1977.

   -quarterly incidence in FY 1979 will be 33 percent lower than in comparable quarter FY 1978.

4. Diphtheria - maintain 80 percent of States free of diphtheria in those under 15 in CY 1978, 85 percent in CY 1979.

5. Tetanus - maintain 85 percent of States free of tentanus in those under 15 in CY 1978, 90 percent in CY 1979.

6. Polio - contain outbreaks in no more than one generation following initial case.

Based on death to case ratios, similar reductions in deaths are anticipated.

Senator Kennedy - Hypertension - Question No. 1

1. Prior to the enactment of 314(d) (7)(B), what was the extent of State programs in hypertension identification, screening, diagnosis, and referral for treatment?

Answer:

As reported through the Association of State and Territorial Health Officials (ASTHO) Public Health Reporting System for fiscal year 1975, only three State health agencies (Alabama, Mississippi, and New Mexico) had separate hypertension programs. Forty-five States reported that screening for hypertension was included in various other programs.

Senator Kennedy - Hypertension - Question No. 2

2. What effect has the Federal formula grant program had over the last two years in stimulating expansion and improving the effectiveness of the State hypertension programs?

Answer

Inasmuch as data is not yet available on a nationwide basis describing State hypertension services prior to the separate authorization of funds under section 314(d)(7)(B), funds for hypertension control, we cannot measure the extent of expansion the funds have stimulated. The funds were used, in some cases, to start new separate hypertension programs and, in other cases, to supplement the preexisting activities in the State. One State indicated that the 314(d) hypertension monies more than doubled the usual level of program support. These funds were described as the "key to program development, and in providing direct financial aid to local health agencies."

Senator Kennedy - Hypertension - Question No. 3

3. If hypertension were not a separate categorical program but were organized as part of a general prevention package, and if the States had greater flexibility in funding the early detection program with Federal funding, what developments do you see in State support of hypertension screening programs?

Answer

Under a broad prevention authority, having a flexible authorization and appropriation, States would have the latitude to use amounts for hypertension which are greater or lesser than are now specifically allocated toward hypertension under the existing specific authority. We know of no way to forecast what approach the States would take. However, the current approach does provide a minimum level of resources for hypertension programming in each State. Unlike many diseases hypertension is not readily apparent until it reaches advanced and critical stages. This specific level of resources insures that no State will ignore hypertension problems.

Senator Kennedy - Hypertension - Question No. 4

4. What data do you have concerning the extent to which the State programs in hypertension are effective in identifying and referring individuals with hypertension? How many people are being screened in the States? At a cost of approximately $.50 per screening test, how well is the Federal money being used in terms of the numbers of individuals actually being examined?

Answer:

At this point data is not available regarding the number of people being screened for hypertension. Beginning with fiscal year 1977, with the approval of the Office of Management and Budget, the States will be asked to report the number of people screened by sex and age groups (under 18, 18-44, 45 and over) and number of newly diagnosed hypertensives by sex and age groups. In addition to screening, funds are being expended for public education, patient education, professional education, diagnosis, and for patient monitoring, including follow-up, all of which are essential for control of hypertension.

Senator Kennedy - Hypertension - Question No. 5

5. If you are not presently receiving this data, how effective do you believe the voluntary reporting system of the ASTHO will be in providing these data?

Answer:

The Public Health Program Reporting System of the Association of State and Territorial Health Officials (ASTHO) has sufficient flexibility and capability to collect requested data regarding the hypertension control program. Some States are likely to have difficulty in reporting unless the reporting requirements are determined in advance. Otherwise, the necessary records and data for State reporting may not be kept. Clearance from the Office of Management and Budget has been requested for data collection for fiscal year 1980 and beyond.

Senator Kennedy - Hypertension - Question No. 6

6. Considering the total cost of treatment of hypertension in this country is approximately $4 and one-half billion annually, early detection and treatment seems to be the correct and most realistic approach to preventive care for cardiovascular disease. Do you support a vigorous, categorical approach to hypertension as is presently contained in 314(d)(7)(B)? If not, why not? The present program allows State flexibility within the development of a screening program, does it not?

Answer

In order to develop and establish programs for the screening, detection, diagnosis, prevention, and referral for treatment of hypertension, a categorical approach, such as presently contained in section 314(d)(7)(B) is warranted and desirable. When such programs have been adequately developed and become fully operational, a categorical approach may no longer be the most desirable approach to accomplish the objectives of the program within the overall health mission of the State. The present program does allow States sufficient flexibility for the development of screening activities.

Senator Kennedy - Hypertension - Question No. 7

7. Do you support folding in the present formula grant hypertension program into a general preventive disease grant authority, with the State free to propose the level of their State expenditures as between a number of preventive disease programs? What effect do you see this having on hypertension screening, identification, diagnosis, and referral to treatment programs in the States?

Answer:

We support an extension of the hypertension program under a separate legislative aughorization and not as a part of the preventive services grant authority. Should the hypertension program be included in a general preventive disease grant authority, with the State free to propose the level of their expenditures as between a number of preventive disease programs, it is possible that some States would not develop and establish hypertension control programs to the extent they would under a separate allotment for this program.

Senator Kennedy - National Health Service Corps (NHSC) - Question No. 1

Approximately 94 percent of the NHSC is presently in rural areas. I understand that as of FY 1979 sixty percent of the new assignees will be going to urban areas, and that by 1985 the urban/rural assignments should be divided evenly. How are you able to make such a rapid switch in placement? Where will these doctors be placed in the cities? What is your policy in regard to urban vs. rural placement?

Answer:

Our current expectations for 1979 are that half of the new Corps staff will be assigned to urban areas. Taking this into account, when we combine the new staff with existing assignments, our overall staffing distribution for 1979 should run 30-35 percent urban and the remaining 65-70 percent rural. Our expectation for 1983 is a 35 percent urban and 65 percent rural distribution. The change in distribution for 1979 can be accomplished by emphasizing urban matches with the new assignees and not by moving any persons presently in NHSC sites. This is possible because of the large numbers of persons who will become available in the next few years from the scholarship program. In the urban areas, doctors will be assigned to Community Health Centers, and other ambulatory health care facilities which serve the residents of health manpower shortage areas. This is similar to the recent rural placements. One difference is that now with P.L. 94-484, it is possible to designate facilities and more urban health manpower shortage areas.

The policy with regard to the urban/rural placements is to follow the intent of the law. Priority in assignment is to be toward the areas of greatest need - wherever they are - in urban or rural areas. However, it should be understood that effective matching of assignees to sites must continue to be taken into consideration as well.

Senator Kennedy - National Health Service Corps - Question No. 2

2. What has been the retention in NHSC for practitioners, i.e., permanent settling out in a community? This does not include those who extend an extra year for their convenience.

Answer

The rate for NHSC practitioners settling permanently in a community has for the past two or three years been about 12 percent of the assignees who complete their tour of duty that year.

Senator Kennedy - National Health Service Corps (NHSC) - Question No. 3

What should be done to enhance retention and health services stability in those communities which are having consistent turnover?

Answer:

Failure of communities to retain their assignees is generally attributed to one or more of such factors as professional isolation, spouse dissatisfaction, social and/or cultural differences and deficiencies and personality conflict. We believe that it is essential now to begin to analyze those communities that have a consistent turnover to determine exactly why the turnover occurs and to begin to take steps to counteract this. For example, we believe that for those communities that have social and/or cultural deficiencies that a careful search and an extra careful matching effort will enhance the opportunities of retaining professionals. We believe that a very careful and comprehensive analysis of the individual's desires and the community's resources, will help avoid many turnover problems. For those communities where there is professional isolation we believe that by providing the assignees with even greater involvement with a teaching facility or a State medical teaching institution and by providing him with various other services such as are now provided by contract with the AMA Reference Library in Chicago or the dial access tapes through the University of Wisconsin, we can begin to reduce the feeling of professional isolation. Among the communities with highest turnover are those with a single provider. The NHSC will attempt to assign more than a single provider to all sites which have a potential patient population to sustain more than one provider. Sites with only one provider may be terminated or combined when the sole provider decides not to remain.

We now make and expect to continue efforts to involve spouses in the processes of learning about NHSC activities, assessing communities, and identifying preferred assignments. We expect to maintain a vigorous monitoring program in order to identify and resolve, at the earliest possible time, personality conflicts.

Senator Kennedy _ National Health Service Corps - Question No. 4

4. Is there a change of program intent and philosophy in the Corps? That is, is it moving from an emphasis of hopeful long-term commitment of a practitioner to a community toward an expected or planned two year turnover of NHSC personnel?

Answer

There is no change of intent and philosophy in the NHSC program. There is the possibility that this could occur because of the increase in size and emphasis brought about by P.L. 94-484. Therefore, we are making special efforts to continue to provide a high level of assistance in matching NHSC personnel to sites and in supporting them once they are placed in a community. We hope through these efforts to continue to provide a positive experience for NHSC assignees to improve the quality of services they provide and to encourage them to remain in communities when their assignment period is complete.

The scholarship provisions in themselves will result in a four year commitment for scholarship recipients. We are hopeful that the chances of retention will be even greater because many assignees will be spending four years in a community rather than two.

The retention rate of scholarship recipients could probably be improved to the extent that special care is taken in the awarding of scholarships to ensure that students with related ethnic characteristics and experience in shortage backgrounds are given special consideration.

Currently, we have had so few scholarship recipients serve in the field that there is little experience on which to establish a retention rate for them. In the meantime, for planning purposes we estimate that their retention rate will be about 20 percent.

Our retention rate of volunteers who have completed their service obligation has steadily improved so that we expect that this year 50 percent of assignees finishing obligated service will remain in the area in the NHSC or in private practice.

Senator Kennedy - National Health Service Corps - Question 5.

5. Does the Administration feel that NHSC recruits are adequately prepared to deal with their field responsibilities through present levels of orientation and field support?

Answer

We believe that the assistance provided through orientations for NHSC personnel and through contracts and direct technical assistance provided to NHSC personnel for setting up practices, and for practice management and patient management is adequate. We hope to add greater emphasis to the preparation and continuing capability of NHSC personnel through such programs as are now being conducted at the University of New Mexico and Hershey, Pennsylvania wherein the continuing medical education of NHSC assignees is closely scrutinized by faculty members from these institutions. Also, improved utilization of the capabilities of the Area Health Education Centers (AHECs) could assist in this regard. Elements of the answer to Senator Kennedy's retention question (No. 3) are relevant to this inquiry.

Senator Kennedy - National Health Service Corps - Question No. 6

6. The President's budget for FY 1979 allocates $60 million for the NHSC scholarships in the Bureau of Health Manpower. How many students will get scholarships for the first time under this sum?

Answer

P.L. 94-484 has added a new category of expenses which the scholarship program will pay -- all other reasonable educational expenses. We estimate that the total cost per student per year of support will be $11,000. That estimate will yield about 5,400 scholarships. Based on the FY 1978 request for scholarships of $60 million and the large number of 1978 awards which will go to students who will be continuing into 1979, it is expected that there will be little money left for new awards in 1979. The estimated distribution of awards at the 60 million scholarship funding level is 4,600 continuations and 1,200 new awards.

Senator Hathaway - Community Health Centers - Question No. 1

1. It has been alleged that a disproportionate share of the community health center funds provided under section 330 are allocated to urban health centers. Could you provide for this subcommittee a breakdown, for the most recent fiscal year, of the number of projects funded and the amount of funds expended in the following categories:

   a. Urban comprehensive community health centers
   b. Rural comprehensive community health centers
   c. Rural Health Initiative projects
   d. Urban Health Initiative projects

Answer

Data are for FY 1977:

	Number of Projects	Funding (000's)
Total	455	$215,148
a. Urban comprehensive community health centers	113	143,484
b. Rural comprehensive community health centers	45	40,470
c. Rural Health Initiative projects	262	23,599
d. Urban Health Initiative projects	35	7,595

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Senator Hathaway - Community Health Centers - Question No. 2

As you know, Senator Javits has introduced an amendment calling for the establishment of an Urban Health Initiative as a part of the community health program. In your opinion, would the existing need for such services in rural medically underserved areas justify the broadening of this proposed program to include both urban and rural community hospitals as recipients of the financial assistance, or the establishment of a similar program to meet the special needs of rural communities? If "no" to both questions, why not?

Answer:

Senator Javits' proposal, section 106 of S. 2474, provides for establishing primary ambulatory care centers using, as a base, urban hospital outpatient departments and emergency room services and facilities. This proposal would allow existing community providers to reorganize themselves to provide care more efficiently, reduce inappropriate utilization, and redirect resources to needed comprehensive ambulatory primary care services. (This proposal is not the same as the existing Urban Health Initiative which the Bureau of Community Health Services is implementing under current section 330 authority.)

Because of the difference in the modes of health care delivery between rural and urban areas, Senator Javits' proposal is generally not suitable for application in rural areas.

While rural communities often lack resources, especially manpower, to provide care, they usually do not have the problems of improper utilization and overspecialization common in urban communities which result in the provision of care to large segments of the population through inappropriate utilization of emergency rooms and specialty oriented clinics. In general, rural communities require additional resources while urban communities tend to need reorganization of the ample resources which already exist. In many urban communities, this requires extensive remodeling of facilities.

More flexible programming is currently being carried out in rural areas under the HURA (Health Underserved Rural Area) authority of the Social Security Act, section 1110. However, the conference committee on the FY 1978 appropriation has said no further funding will be provided under the section 1110 authority and directs DHEW to seek authorization under Section 330 of the Public Health Service (PHS) Act. This could be accomplished simply through the addition of a new section in the PHS Act which would provide the necessary flexibility to develop appropriate systems for rural areas where current section 330 authorities are inapplicable or inappropriate.

The Administration has proposed that formal authority for HURA be incorporated into the PHS Act as a new section 329. This new section would provide support for the developmental and demonstration activities which are needed to meet the unique primary health care needs of rural areas in those instances where section 330 funding is not appropriate. In addition, if conversion of hospital outpatient services were uniquely appropriate in any particular rural area, this conversion could be accomodated either under section 330 or the newly proposed developmental and demonstration section.

Senator Hathaway - Community Health Centers - Question No. 3

What modifications, if any, would be required in existing regulations governing the funding of comprehensive community health centers to enable a larger number of smaller rural communities to develop and operate community health center programs? For example, it has been suggested that existing requirements for the provision of the full range of primary health care services outlined in section 330(b) of the Act restricts participation by smaller communities in the program. Do you believe that the current regulations reflect an urban bias in the way the program is administered?

Answer:

The regulations governing the Community Health Centers program are based on the legislative requirements of Section 330 of the Public Health Service Act. The regulations describe the full range of health care services required by the Act at a level we consider adequate for effective health care. The legislative and regulatory requirements may present problems to some rural communities, especially those that are sparsely populated and remote. Where the Community is remote and the population base is too small to maintain full time staff locally, special arrangement may be made to deliver services by making use of other area resources.

Senator Hathaway - Community Health Centers - Question No. 4

It has been alleged that current funding priorities within the Department restrict funding under the section 330 programs to the provision of primary health care services, and that the Department has not actively encouraged and supported funding for supplemental and environmental as outlined in the Act? Have existing Departmental policies restricted funding to only primary care services, and if so, on what basis?

Answer:

With respect to established community health centers, the Department has not restricted funding to the provision of primary health care services but rather has supported a fairly broad array of health services. With respect to Urban Health Initiative (UHI) and Rural Health Initiative (RHI) projects, the Department has concentrated on primary health care services which include physician services, diagnostic laboratory and radiologic services, preventive health services, emergency medical services, transportation services and preventive dental services. When these projects have developed the capacity to deliver primary health care services, the Department may initiate support of supplemental health services.

Senator Javits - Community Health Centers - Question No. 1

1. Would you please describe the Health Underserved Rural Areas program (HURA)? Could a program of this nature be expanded to urban areas? (Please include examples of the kinds of projects which would be funded under such a program if the authority were available.) If one assumes that section 330 is the logical statutory base for such an effort, what changes would have to be made to section 330 to allow you to accomplish the desired objectives?

Answer:

The Health Underserved Rural Areas (HURA) Program is a component of the capacity building strategy of the Bureau of Community Health Services. It is funded by Title XIX of the Social Security Act under Section 1110, General Research Authority. It establishes developmental and testing projects in health underserved rural areas for the following purposes:

- attract physician assistants and nurse practitioners to rural areas to supplement and attract additional physicians
- emphasize programs of health education and preventive health care
- gain full utility from the available medical resources in rural areas
- coordinate with Maternal and Child Health, Early and Periodic Screening, Diagnosis and Treatment, and cancer screening programs of the National Cancer Institute to allow all these resources to be brought to bear to increase health care to mothers and children in medically underserved areas
- develop methods of organization that utilize the basic medical funding programs and new methods of delivery

The HURA Program works with already established providers of care who wish to expand their service in rural areas or develop particular organizational or technical demonstrations aimed at improved service or financing structures.

The program could be expanded to urban areas. Under such an urban program, hospitals, private nonprofit group practices, medical schools, etc., could develop community health service projects serving urban areas in need of health services delivery improvement. Such projects could include the use of nurse practitioners, physician assistants, new organization models or other appropriate technology to develop systems of care.

Senator Javits - Community Health Centers - Question No. 2

2. It is my understanding that, according to HEW calculations, it currently costs approximately $1.5 million to establish a community health center in an urban area and $150,000 to establish one in a rural area. Would you explain this cost differential and supply, for the record, any information regarding how funds under section 330 are being spent (i.e. how much for planning, how much for renovation and modernization, how much for direct patient services, how much for indirect costs like overhead, salaries, etc.).

Answer

Since 1975, the Public Health Service (PHS) has been funding new centers under the Rural Health Initiative (RHI), and since 1977, the PHS has been funding new centers under the Urban Health Initiative (UHI). Experience with these two initiatives indicates that the average grant for the first year of funding, which is primarily to cover development and initial operations costs, was $150,000-$200,000 for the RHI centers and $285,000-$325,000 for the UHI centers. The cost differential of approximately $125,000 can be attributed to the following:

A. Difference in Group Practice Model:

The UHI model consists of 5-6 primary care physicians with 1 to 2 nurse practitioners and a dental hygienist and is designed to service a minimum patient population of approximately 10,000 persons (in the first year of operation about 5,000 and the second year on, about 10,000) while the RHI model consists of 3 to 4 primary care physicians with about the same ratio of other allied health personnel to serve approximately 6,000 persons (in the first year of operation serving about 3,000 and the second year on, about 6,000).

B. Integration of Resources:

The assignment of the National Health Service Corps (NHSC) personnel to the RHI projects and UHI projects is one of the priority objectives of the capacity building activity. To date, however, we have had more successes in the placement of the NHSC personnel in the development of primary care group practices of health professionals within the rural underserved areas than in the urban areas. Over 100 RHI projects currently are matched with the NHSC personnel whereas only 6 UHI projects are currently matched with the NHSC personnel.

C. Space Acquisition, Renovation and Modernization Costs:

Initial investment and start-up costs (including limited capital and renovation costs) associated with developing a primary care health project in urban areas have been assumed to be slightly higher than in rural areas.

As of 1977, the distribution of total operating costs of Community Health Centers (CHCs) was as follows. The amounts shown are the total funds available to support all CHCs which were $370,944,827, of which $215,148,000 represent section 330 appropriated funds (58 percent of the total operating costs); $114,992,896, third party reimbursements (31 percent of the total operating costs); and $40,803,931, State, local, and other contributions (11 percent of the total operating costs). Approximately 70 percent of the total operating costs are for salaries:

	Percent	Dollars
Direct Patient Service (Medical, Dental, Lab, X-Ray, Pharmacy and other Health)	65	$241,150,000
Supporting Services (Outreach, Transportation, and Medical Records)	11	$ 40,810,000
Overhead	24	$ 89,040,000
Administration	(17)	$ 63,070,000
Housekeeping and Maintenance (Including depreciation of facilities)	(7)	$ 25,970,000

Of the $215,148,000 appropriated funds in 1977, a total of $23,598,524 was expended to support 262 RHI projects, of which 43 projects were funded as Planning/Developmental projects with $1,917,253, and a total of $7,595,031 was expended to support 35 UHI projects, of which 3 projects were planning/developmental projects with $50,000.

Senator Javits - Community Health Centers - Question No. 3

3. Please provide a detailed breakdown of currently approved projects (including RHI and UHI) by category as they relate to urban and rural areas. I would like for you to include a per capita allocation of grant monies per eligible medically underserved recipients in urban and rural areas. Also please indicate how you anticipate spending any new funds, as proposed for authorization under S. 2474, in urban and rural areas. Be specific.

Answer

A detailed breakdown of the projects and per capita allocations of grant funds are displayed in the attached Tables 1 and 2.

Table 1 (attached)
Table 2 (attached)

The administration's budget request for FY 1979 of $286,000,000 for the Community Health Centers includes $27,700,000 to fund an additional 131 projects. Eighty-five (85) of the projected 131 new projects will be established in the rural areas ($12,750,000), and 46 projects in the urban areas ($14,950,000).

Table 1
Rural and Urban Breakout of the Community Health Centers

Community Health Centers	1977 Projects No.'s	1977 Projects % of Total	1977 Funding $	1977 Funding % of Total	1978 Projects No.'s	1978 Projects % of Total	1978 Funding $	1978 Funding % of Total	1979 Projects No.'s	1979 Projects % of Total	1979 Funding $	1979 Funding % of Total
On-going CHC's												
Rural	45	10%	$ 40,470	19%	45	8%	$ 44,408	18%	45	6%	$ 52,347	18%
Urban	113	25%	$143,484	67%	113	20%	$157,445	64%	113	16%	$165,767	58%
RHI	262	58%	$ 23,599	11%	356	62%	$ 31,187	13%	441	63%	$ 39,688	14%
UHI	35	7%	$ 7,595	3%	60	10%	$ 13,960	5%	106	15%	$ 28,198	10%
CHC Total	455	100%	$215,148	100%	574	100%	$247,000	100%	705	100%	$286,000	100%
Rural	307	67%	$ 64,069	30%	401	70%	$ 75,595	31%	486	69%	$ 92,035	32%
Urban	148	33%	$151,079	70%	173	30%	$171,405	69%	219	31%	$193,965	68%

Table 2

Per Capita Use of Section 330
Grant Funds in Urban and Rural Projects

	1977		1978		1979	
	Rural	Urban	Rural	Urban	Rural	Urban
Total Section 330 Grant Dollars:						
Continuation Projects	$40.5	$143.5	$44.4	$157.4	$52.3	$165.4
RHI	$23.6	---	$31.2	---	$39.7	---
UHI	---	$7.5	---	$14.0	---	$28.1
Grant Dollars per capita 1/	$41	$81	$33	$75	$31	$73

1/ Using only Section 330 funds. Not included in this computation, particularly for RHI projects, are other federal resources such as Migrant grant funds and National Health Service Corps resources. Computation of per capita use of section 330 funds is based on persons served in CHCs.

Senator Javits - Community Health Centers - Question No. 4

4. Please provide a "current policy budget" (continuation of current activity plus inflation adjustment) for currently approved projects (including RHI and UHI) by category for fiscal 1979, 1980, and 1981, comparing these figures (in adjacent columns) with (a) funds requested by the Administration for continuation of this program, and (b) funds proposed for authorization under S. 2474, and (c) funds proposed for authorization under H.R. 10553.

Answer

(a) Continuation costs for currently approved projects plus inflation adjustments:

	Continuation costs for currently approved CHC projects ($ in millions)		
	1979 1/	1980 2/	1981 3/
On-going CHCs	$218.1 4/	$230.5	$243.4
Rural Health Initiative	39.7	42.0	44.3
Urban Health Initiative	28.2	29.8	31.5
Health Underserved Rural Areas	15.0	15.9	16.8
Total - current policy projection	$301.0	$318.2	$336.0

(b) Funds proposed for authorization under S. 2474 for Community Health Centers:

	1979	1980	1981
Planning	$ 10,000,000	$ 10,000,000	$ 10,000,000
Operations	320,000,000	352,000,000	387,200,000
Urban Hospital Initiative	34,000,000	72,000,000	114,000,000
Total	$364,000,000	$434,000,000	$511,200,000

(c) Funds proposed for authorization under H.R. 10553 for Community Health Centers:

	1979	1980	1981
Planning	$ 6,300,000	$ 7,500,000	$ 9,000,000
Operations	308,700,000	367,500,000	441,000,000
Total	$315,000,000	$375,000,000	$450,000,000

1/ Does not include inflationary adjustment
2/ 5.7% of inflationary adjustment
3/ 5.6% of inflationary adjustment
4/ Includes adolescent health set-aside funds and others

Senator Javits - Section 314(d) - Unnumbered Question

How much is known about the accomplishments of State programs which spend funds under Section 314(d)? Why has DHEW not imposed more specific reporting requirements?

Answer:

Through the Health Program Reporting System of the Association of State and Territorial Health Officials (ASTHO), supported by the Health Services Administration, the expenditures by State health agencies of section 314(d) funds are reported by the following program areas and categories: personal health programs (general, maternal and child health, communicable disease, dental health, chronic disease, other), environmental health programs (general, consumer protection and sanitation, radiation control, public drinking water and water pollution control, other), health resources programs (health planning, health facilities and services development, health manpower development, health facilities and services regulation, health manpower regulation, health statistics, emergency medical services, general), State laboratories, general administration and services, and funds to local health departments not allocated to program areas. Total expenditures of State and Federal funds by these program categories are also reported as are also the number of persons served, with a further breakdown in certain personal health programs. A significant increase in reporting for maternal and child health and crippled children's program beginning with fiscal year 1977 and an inclusion of more detailed reporting from local health departments is expected beginning in fiscal year 1978.

Previous to March, 1976 two major reports, the FAR and FAST task forces, were developed with the objectives of significantly reducing the time and effort devoted to plan preparation and reporting requirements. As a result of those efforts, decisions were made to radically reduce planning materials.

Since March 1, 1976, the Department has been subject to a Presidential directive to reduce public reporting to Federal agencies in order to implement the Federal Reports Act (44 U.S.C. 3501-3512). The Office of Management and Budget has the responsibility for the clearance of all reporting requirements affecting 10 or more respondents. The Department currently has as an objective the reduction of the reporting burden associated with HEW repetitive reports by 50 percent by May 31, 1978. The burden reduction is measured in terms of hours of burden assigned to a reporting form in the June 30, 1976 OMB inventory or upon its entry into the OMB inventory, if after that date.

Senator Javits - Migrant Health Centers - Unnumbered Question

During the question period following your testimony, the issue of establishing Medicaid eligibility for migrants based on "intent to reside" was raised. Would you please elaborate on how the determination of this intent would be made?

Answer:

Presently, when a person is interviewed with regard to his request for certification for State Medicaid benefits, many States ask if the person intends to reside within the State. Often Medicaid benefits are denied when the person states that he does not intend to become a State resident. This is particularly true of migrant workers who by the very nature of their work cannot claim permanent State residence.

The Department has under consideration an approach removing these restrictions by prohibiting States from denying Medicaid benefits to migrants on this basis.

The proposal would specifically address the migrant problem and make migrants eligible for Medicaid reimbursable health services within the income limits and service benefit package of the State. It would not involve billings between States but would mean that migrants would have varying eligibility for different levels of services as they traveled from State to State.

Senator Javits - Miscellaneous - Unnumbered Question

It is my understanding that the National Association of Neighborhood Health Centers and Rural America, each representing the interests of organizations funded under the Community Health Centers program, receive support from the Bureau of Community Health Services. Could you advise how much support is directed to these and related organizations and from what program(s) this money is obtained? Is there a conflict of interest in trade associations representing those who receive project grants from your office also receiving support funds for their activities? Is it appropriate that the same agency that is charged with evaluating the effectiveness of such programs gives financial support to associations representing these groups?

Answer:

The National Association of Community Health Centers (NACHC) is an organization whose staff and membership have experience in the planning, development, and operation of community and migrant health centers. Their experience is directly related to the areas--underserved areas--which frequently lack the technical expertise and resources within the community to plan and develop ambulatory health care service delivery programs. As such, these individuals are uniquely qualified to provide assistance to community and migrant health centers.

The NACHC has been awarded a technical assistance grant of $875,000 for fiscal year 1978. The grant is funded from the following sources: $765,000 from Section 330 of the Public Health Service Act and $110,000 from Section 319 of the same Act.

The California Rural Health Federation and the Rio Grande Federation of Health Centers, Inc. are other organizations that assist communities in the development of primary care programs in their respective rural areas. The membership of the organizations are primary care centers serving large migrant and seasonal farmworker populations.

The Bureau of Community Health Services (BCHS) has awarded grants of $70,000 to the California Federation and $104,000 to the Rio Grande Federation.

The work plans submitted by these organizations and approved by BCHS contain objectives that support the provision of technical assistance to migrant and community health centers. The authority for the Secretary to provide necessary technical assistance is given in Section 330(f) and Section 319(g) of the Act, for community health centers and migrant health centers, respectively. Assistance may be given for developing plans for, or operating as, a community health center or migrant health center. Specific activities contained in the NACHC workplan for 1978 include:

1. To assist "high priority" Medically Underserved Areas to develop applications for urban and rural health initiative grants.

2. To improve health service program effectiveness by providing onsite technical assistance to community health service programs. Assistance shall include, but not be limited to, the following areas:

   a. Financial Management
   b. Clinical Management/Quality Assurance
   c. Administration
   d. Board Training
   e. Facility Development
   f. BCHS Initiatives (Adolescent Health etc.)

3. To provide opportunities for continuing education for health care administrators, providers, board members, and consumers of member and non-member health service programs by conducting one national and ten regional Community Health Institutes.

4. To help alleviate health manpower shortage problems in medically underserved communities by assisting MUAs to request and obtain designation as Critical Health Manpower Shortage Areas.

5. To improve the long term financial viability of certain community health service programs by developing strategies for converting such programs to prepayment financing mechanisms and disseminating this information to member and non-member community health service programs.

6. To educate nationally, the persons involved with the community health center movement by producing and disseminating information on program policy, development and operation.

7. To provide a forum for the discussion of specific health care issues of national and regional significance by conducting a series of National Health Policy Issues Conferences on the following topics:

   a. Continuity of Care for Migrant Populations
   b. Quality Assurance Issues in Ambulatory Care
   c. Solving Environmental Health Problems through Community Health Services
   d. Rural Health Care Consortia and Regional Health Delivery Systems: Models for Meeting Health Care Needs of Rural Populations
   e. Strategies for Improving Program Management
   f. Partners in Health Care Delivery, Community Health Centers and General Hospitals

Rural America was awarded a 6 month contract in fiscal year 1977 of $28,260 to identify and prepare a directory of non-Federal national and regional organizations concerned with rural health care or actively involved in improving rural health conditions and to plan and conduct, as part of their Third National Conference on Rural America, a session

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on how to coordinate and maximize and integrate these resources to improve rural health care. Copies of this directory, when finalized, will be distributed to communities interested in developing health care systems to aid them in indentifying resources. This contract was supported with National Health Service Corps funds and was part of the overall Bureau of Community Health Services capacity building strategy designed to integrate resources and develop linkages between health care providers.

It is our understanding that Rural America is not a trade organization but a rural membership organization whose interest has been in agriculture, housing transportation, and more recently, health. Their work with and knowledge of the many rural organizations interested in improving health care delivery, but not directly associated with health care delivery, enabled this Bureau to obtain valuable information which will contribute to the further identification of non-Federal health care resources available to rural communities and aid these communities to develop their capacity to provide health care. The Third National Health Care Delivery Conference brought together persons with knowledge of the many areas of rural life.

It is our view that activities such as those described above, are appropriate and essential to the work of this Bureau and do not present any conflict of interest. We believe that subsidization of such organizations would be inappropriate; but we regard making use of their special capabilities to carry out specified activities to further the development or improve the operation of health centers as a sound management practice.

SENATOR JAVITS - NATIONAL HEALTH SERVICE CORPS - Unnumbered Question

It has come to my attention that the National Health Service Corps has a very limited program to support the development of State health service corps activities. Given the generally favorable reception of the National Health Service Corps and the demonstrated interest of States to become more active in this type of program, why has not more been done to decentralize Corps activities through State participation? What action would be needed by the Congress to demonstrate its commitment to the support of increased State activity in this area?

Answer

Some activity in this area is under way at the present time. Contracts to support the development of State Health Corps operations in Oklahoma, Mississippi and Arizona were awarded in 1976. We are currently negotiating for such programs with several other States including Arkansas, Pennsylvania and Alabama and we have inquiries from West Virginia and North Carolina. The Health Services Administration has plans to launch an aggressive program this year to foster better relationships between the more than 20 States with some form of a Health Service Corps and the National Health Service Corps. The California operation is particularly interesting inasmuch as their law was essentially a reproduction of the National Health Service Corps authority.

One of the problems remaining to be ironed out is the question of the potential conflict of dual service obligations. For example, when a student with an obligation to a State applies for and receives a National Health Service Corps scholarship, can a placement in that State be arranged and thereby satisfy both obligations? This becomes a problem when there are more students with State obligations than can be assigned to a State on the basis of greatest need.

Serious discussions are under way now to attempt to resolve these problems in a mutually satisfactory manner and if this can be arranged it is likely that emphasis will be placed on establishing and improving the State Health Service Corps operations.

At this point, we do not believe that any action is required on the part of the Congress. It may be useful to have the report contain an expression of interest in this activity, as well as an indication that efforts in this regard should continue.

Senator JAVITS. Thank you very much.

Senator HATHAWAY. The next group of witnesses is a panel on health centers: Dr. Daniel Davis, Basilio F. Romero, Dr. Lorin Kerr, and Dr. James A. Block.

Dr. Davis?

STATEMENT OF DANNY K. DAVIS, PH.D., PRESIDENT, NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS, INC., WASHINGTON, D.C., AND SPECIAL ASSISTANT TO THE PRESIDENT OF MILE SQUARE HEALTH CENTER OF CHICAGO, ILL., ACCOMPANIED BY L. JEROME ASHFORD, EXECUTIVE DIRECTOR OF THE NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS

Dr. DAVIS. Mr. Chairman, my name is Danny Davis and I am special assistant to the president of the Mile Square Health Center in Chicago, and president of the National Association of Community Health Centers. I am accompanied today by Mr. Jerome Ashford, who is executive director of the National Association of Community Health Centers. And Jack Cradock from the Massachusetts League of Health Centers was supposed to be here, but the weather conditions in Boston prevented him from doing so. However, he will be submitting testimony.

On behalf of the National Association of Community Health Centers and the thousands of medically unserved and underserved families who benefit from these programs, I want to thank you and members of the subcommittee for this opportunity to share with you our views on Senate bill 2474. We share your concerns for this Nation's unserved and underserved, and commend your subcommittee for its efforts to translate this mutually shared concern into effective legislation.

The membership of our association is representative of the diverse community and migrant health center models designed to meet the health service needs of America's medically unserved and underserved populations. Through their representatives, these organizations have had the opportunity to review S. 2474.

I would like to take this opportunity to submit to you our assessment of the merits and deficiencies of the proposed legislation, as well as some recommendations regarding broader health-related issues.

One, that community health center and migrant health programs be extended for a 5-year period through fiscal year 1983; we wholeheartedly support your recent floor statement that, "The health center programs have now reached a point where Congress should provide an expression of its confidence and reflect this in a 5-year authorization."

Short period authorizations tend to give a sense of transience to the program. More important, however, is the fact that in the past the result has been disruptions in program funding as appropriations were delayed due to lack of authorizing legislation. At the center level, it has made planning most difficult, and all too often employees have been dismissed because of uncertain or delayed funding.

Recommendation II: That eligibility for grants under sections 330 and 319 be restricted to community-based, private, nonprofit organi-

zations. Community and migrant health centers have developed over the last decade as community-controlled ambulatory health providers with emphasis on prevention. They have shown themselves to be effective both in delivering services to those previously unserved by traditional providers and in being responsive to the unique needs of their target populations, needs which traditional providers have not understood or met. Congress enunciated its support of the community health center model when it eliminated section 314(e).

Senate bill 2474 weakens this commitment to community-based ambulatory care by permitting grants to public general and other nonprofit hospitals. We are sympathetic to the needs of "community hospitals" and agree that many may require Federal support. However, we do not feel that section 330 is an appropriate means of providing support to public hospitals, because section 330 is intended to support consumer-controlled ambulatory care centers.

There already exist numerous resources upon which public hospitals can draw, such as section 314(d) of the Public Health Service Act, and categorical programs, such as community development under HUD, Economic Development Administration, and Comprehensive Employment and Training Act funds under Labor. In addition, Mr. Rogers bill, H.R. 10553, is proposing to increase the authorization for 314(d) to $300 million from the current appropriation of $90.

The proposed legislation—refer to section 330(b)(3)(6)—would not only permit funding grantees who are not part of the community health center model, but also would permit such grantees to construct facilities, while community health centers are limited to renovation. One wonders if this discrimination implies a commitment to the permanence of public hospitals, while regarding community health centers as temporary.

Moreover, public hospitals would merely be required to have an advisory board—refer to section 330(h)(4)(5) which implies no community control and little consumer input, an issue which is central to section 330.

Three. That the list of mandatory primary services be expanded to include a broad range of preventive health services and those services which eliminate barriers to access. Further, the Secretary shall assure that centers are adequately funded for the provision of such services.

Specifically, the following services should be added to the primary category: First, preventive health services for children and adults; second, public health services, including nutrition education and social services; third, health education services; forth, environmental health services as may be appropriate for particular centers; fifth, primary mental health services; sixth, outreach services and other services which promote and facilitate optimal use of primary health services; and, seventh, information on the availability and proper use of health services.

In addition to those services already defined as primary, the above services compliment a range of health care and a philosophy which have led these programs to their successful track record; that is, accessability, quality, prevention, and substantial reductions in costly inpatient care.

Mr. Chairman, we would hope this committee will take a lead in establishing a health policy of this nature by guaranteeing that through these programs, a certain minimum of health services will be available to all people. The services that we contend should be mandatory fall into three groupings: First, basic medical and dental care; second, preventive services; and, third, ancillary services which remove barriers to access.

I should point out that we are not asking that all services currently defined in the law become mandatory. The need for this kind of policy is evident when one examines what has happened to the health center programs recently. Grant levels to ongoing programs have in some cases been reduced, and in others not adjusted to keep up with increased costs. This has resulted in reductions of service levels, and in the case of new programs—rural and urban health initiatives—services beyond those which are mandatory are seldom funded, if at all. This is apparent when one examines HSA figures for cost per person served and projected cost per new start, refer to charts C and D.

We recognize the need to reach more of the 49 million medically underserved Americans. We also approve of efforts to improve management and increase productivity. However, we do not believe that the community and migrant health center model should be downgraded through reduction of services.

Four, we believe that the definition of "medically underserved population" should be amended to allow for inclusion of small areas or pockets of poverty within a larger area not presently defined as underserved. There currently are a number of such areas which do not meet the criteria for designation as a medically underserved area, according to regulations.

One area, for example, may have a large teaching hospital, and therefore an "adequate" supply of physicians, even though these physicians may not be available to local residents. Or, in another instance, there may be a number of physicians, none of whom accept medicaid, thus creating an access barrier. Although these areas are not underserved by DHEW definition, significant numbers of the population may not have access to health care.

As the current law speaks to populations and not areas, we feel that the Congress should spell out that such areas or pockets not be excluded, but rather included as areas which may apply for grant funding. We have submitted recommended language to your staff. Of course, priorities and areas of greatest need would still be targeted by HEW regional offices.

Five, we believe that new grants should go to the poorest medically underserved areas; whenever possible that they may be funded through existing community and migrant health centers. The greatest single barrier to access is poverty. A priority should be established to assure that areas of greatest poverty are given precedence. We would recommend those medically underserved areas with a poverty rate in excess of 30 percent be funded first.

Further, where existing community and migrant centers proximate medically underserved areas, priority should be given to these centers to expand their service areas. It is logical to utilize their admin-

istrative capacity and expertise to assure that new projects develop both effectively and efficiently. Further, it would be prudent in view of everyone's concern with reducing administrative costs.

Six, we feel that not less than 5 percent of the funds appropriated under sections 330 and 319 should be made available for purposes of construction or renovation of facilities. Too many of our facilities are less than adequate; some still operate out of trailers. The fact is that although money has been appropriated under other programs, little has ever reached health centers. Under Hill-Burton, for example, hospitals received the lion's share, and under community development corporation or economic development assistance programs, new roads and police stations have been priorities.

We are not asking that new or refurbished facilities be luxurious, but construction and renovation are necessary for three reasons. One, inadequate facilities can impair productivity. For example, having too few examining rooms impedes physician efficiency, or having inadequate laboratory facilities may mean sending tests to other laboratories and require an additional patient visit when the test results return. Two, community health centers should not appear to be "second class" health care if they are to be acceptable to their potential patients. This is particularly important as we look at prepaid and voucher models of financing care. And, three, adequate facilities imply a permanence and a commitment to community health centers as important parts of the total health care system. Lack of permanent facilities has led providers, patients, and the general public to regard community health centers as temporary.

Seven, we feel that health centers should be permitted to use any income which exceeds operating costs to generate funds for development. Projects are, and should continue to be, awarded grants based on projected reasonable costs, less projected reasonable income from State, local, and other funds; fees; premiums; and third party reimbursements. However, projects are well aware that any savings that accrue through efficiency of program administration will be offset by a reduced grant in the following year. The present system reinforces a "spend it or lose it" mentality, project dependence on DHEW, and a feeling of transience.

We recommend that projects be permitted to retain savings they generate by either reducing operating costs or increasing reimbursement. In other words, the following year's grant should not be offset by the amount of excess income. This retention of a development fund would be the same as that currently permitted HMO's, and would provide additional incentive for efficiency.

Development funds would be restricted to expenditure on one of the following, as the project assessed its community's needs: (A) to increase the number of persons served; (B) to increase the number or range of services provided; (C) to improve the quality of services; (D) to develop and maintain a reserve fund to be used in offsetting underestimates of funding needs for approved project activities, and for purposes of complying with State regulations for prepaid health care services; (E) to improve management and operational capabilities, including those related to the maximization of third party reimbursement revenues; (F) to constitute a capital improvements

fund as a means of addressing the problem of inadequate facilities which inhibit productivity and acceptance of community health centers as important and permanent parts of the total health care system.

Mr. Chairman, the above recommendations refer to both community and migrant health centers. I would like to turn to those concerns which affect only the migrant health programs.

[Whereupon, Senator Javits assumed the chair.]

Senator JAVITS. Dr. Davis, would you summarize the rest of your presentation; it will all go into the record.

Dr. DAVIS. All right. Then, in terms of summarizing, we are concerned that the committee bring about closer proximity between authorization and appropriation levels. Senate bill 2474 would increase authorizations for fiscal years 1980 to 1983 by 10 percent per year. We think that this is barely enough to offset inflationary costs, let alone expand programs.

So, what we would propose is that the increase be greater. We recommend for fiscal year 1980 to fiscal year 1983 an increase of 25 percent each year.

We are sorry that we have gone over our time. We would like to thank you for this opportunity to share these feelings.

Senator JAVITS. Thank you very much.

[The prepared statement of Dr. Davis follows:]

NATIONAL ASSOCIATION of COMMUNITY HEALTH CENTERS, Inc.

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STATEMENT OF

DANNY K. DAVIS, PHD

NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS
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TO THE

SENATE COMMITTEE ON HUMAN RESOURCES

SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH

FEBRUARY 9, 1978

RE: S.2474 HEALTH SERVICES EXTENSION ACT OF 1978

Mr. Chairman:

My name is Dr. Danny K. Davis, Special Assistant to the President of Mile Square Health Center of Chicago, Illinois, and President of the National Association of Community Health Centers. I am accompanied today by Mr. Jack Cradock, representing the Massachusetts League of Neighborhood Health Centers, and Mr. L. Jerome Ashford, Executive Director of the National Association of Community Health Centers.

On behalf of the National Association of Community Health Centers and the thousands of medically unserved and underserved families who benefit from these programs, I want to thank you and the members of the Subcommittee for this opportunity to share with you our views on Senate bill S.2474.

We share your concern, Mr. Chairman, for this nation's unserved and underserved and commend you on your effort to translate this mutually shared concern into effective legislation.

The membership of our Association is representative of the diverse community and migrant health center models designed to meet the health service needs of America's medically unserved and underserved populations. Through their representatives, these organizations have had the opportunity to review S.2474.

I would like to take this opportunity to submit to you our assessment of the merits and deficiencies of the proposed legislation, as well as some recommendations regarding broader health-related issues.

RECOMMENDATIONS

I. That Community Health Center and Migrant Health Programs be extended for a five year period, through fiscal year 1983 (refer to Sections 330(g)(1), (g)(2), and Sections 319(h)(1), (h)(2), and (h)(3).[1]

We wholeheartedly support your recent floor statement that, "the health center programs have now reached a point where Congress should provide an expression of its confidence and reflect this in a five year authorization."

Short period authorizations tend to give a sense of transience to the program. More important, however, is the fact that in the past the result has been disruptions in program funding as appropriations were delayed due to lack of authorizing legislation. At the center level, it has made planning most difficult, and all too often employees have been dismissed because of uncertain or delayed funding.

II. That eligibility for grants under Sections 330 and 319 be restricted to community-based private non-profit organizations (refer to Section 330(c)(1), (d)(1),[1] and 319 (c)(1), (d)(1)[1] and proposed new Sections 330(b) and (h).[2]

Community and Migrant Health Centers have developed over the last decade as community-controlled ambulatory health providers with emphasis on prevention. They have shown themselves to be effective both in delivering services to those previously unserved by traditional providers and in being responsive to the unique needs of their target populations, needs which traditional providers have not understood or met. Congress enunciated its

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[1] PL 94-63 as amended by PL 95-83.

[2] Proposed in S.2474

support of the community health center model when it eliminated Section 314(e).

S.2474 weakens this commitment to community-based ambulatory care by permitting grants to public general and other non-profit hospitals. We are sympathetic to the needs of "community hospitals" and agree that many may require Federal support. However, Section 330 is an inappropriate means of providing support to public hospitals because Section 330 is intended to support consumer controlled ambulatory care centers. There already exist numerous resources upon which public hospitals can draw, such as PHS Act 314(d) and categorical programs, Community Development under HUD, Economic Development under HUD and Comprehensive Employment and Training Act funds under Labor. Mr. Roger's bill, HR 10553 is proposing to increase the authorization for 314(d) to $300 million from the current appropriation of $90 million.

The proposed legislation (refer to Section 330(b)(3),(6)[2]) would not only permit funding grantees who are not part of the Community Health Center model, but also would permit such grantees to construct facilities while community health centers are limited to renovation. One wonders if this discrimination implies a commitment to the permanence of public hospitals while regarding Community Health Centers as temporary.

Moreover, public hospitals would merely be required to have an "advisory board," (refer to Section 330(h)(4),(5)[2]) which implies no community control and little consumer input, an issue central to Section 330.

III. That the list of mandatory primary services be expanded to include a broad range of preventive health services and those services which eliminate barriers to access (refer to Section 330(b)(1)and 319(a)(6)).[1] Further, the Secretary shall assure that centers are adequately funded for the provision of such services.

Specifically, the following services should be added to the primary category:

A. Preventive health services for children and adults;

B. Public health services (including nutrition education and social services);

C. Health education services;

D. Environmental health services as may be appropriate for particular centers.

E. Primary mental health services;

F. Outreach services and other services which promote and facilitate optimal use of primary health services; and

G. Information on the availability and proper use of health services.

In addition to those services already defined as primary, the above services compliment a range of health care and a philosophy which have led these programs to their successful track record: i.e. accessability, quality, prevention, and substantial reductions in costly inpatient care.

Mr. Chairman, we would hope this Committee will take a lead in establishing a health policy of this nature, by guaranteeing that through these programs a certain minimum of health services will be available to all people.

The services that we contend should be mandatory fall into three groupings:

1) Basic medical and dental care,

2) Preventive services, and

3) Ancillary services which remove barriers to access.

I should point out we are <u>not</u> asking that all services currently defined in the law become mandatory. The need for this kind of policy is evident when one examines what has happened to the health center programs recently. Grant levels

to on-going programs have in some cases been reduced and in others not adjusted to keep up with increased costs. This has resulted in reductions of service levels. In the case of new programs, Rural and Urban Health Initiatives,services beyond those which are mandatory, are seldom funded, if at all. This is apparent when one examines HSA figures for cost per person served and projected cost per new start. (see charts C and D)

We recognize the need to reach more of the 40 million medically underserved Americans. We also approve of efforts to improve management and increase productivity. However, we do not believe that the Community and Migrant Health Center model should be downgraded through reduction of services.

IV. That the definition of "Medically Underserved Population" be amended to allow for inclusion of small areas or "pockets of poverty" within a larger area not presently defined as underserved. (refer to 330(b)(3))[1]

There currently are a number of such areas which do not meet the criteria for designation as a Medically Underserved Area, according to regulations.[3] One area, for example, may have a large teaching hospital, and therefore an "adequate" supply of physicians, even though these physicians may not be available to local residents. Or, in another instance, there may be a number of physicians, none of which accept Medicaid, thus creating an access barrier. Although these areas are not underserved by DHEW definition, significant numbers of the population may not have access to health care.

As the current law speaks to populations and not areas, we feel Congress should spell out that such areas or pockets not be excluded, but rather included as areas which may apply for grant funding. We have submitted

[3] "Medically Underserved Areas" were determined through a weighted "index of medical underservice" which used 4 indicators:
A) infant mortality rates
B) population to physician ratio
C) % population aged 65 and over
D) % population below poverty level

recommended language to your staff. Of course, priorities and areas of greatest need would still be targeted by HEW regional offices.

V. That new grants go to the poorest Medically Underserved Areas; wherever possible that they may be funded through existing community and migrant health centers. (no reference)

The greatest single barrier to access is poverty. A priority should be established to assure that areas of greatest poverty are given precedence. We would recommend those Medically Underserved Areas with a poverty rate in excess of 30% be funded first.

Further, where existing community and migrant centers proximate medically underserved areas, priority should be given to these centers to expand their service areas. It is logical to utilize their administrative capacity and expertise to assure that new projects develop both effectively and efficiently. Further, it would be prudent in view of everyone's concern with reducing administrative cost.

VI. That not less than 5% of the funds appropriated under Sections 330 and 319 be made available for purposes of construction or renovation of a facility. (refer to Section 330(c)(1), (d)(2) and Section 319(c)(1), (d)(2).)

Too many of our facilities are less than adequate, some still operate out of trailers. The fact is that althogh money has been appropriated under other programs little has ever reached health centers. Under Hill Burton, for example, hospitals received the lions' share and under CDC or EDA programs, new roads and police stations have been priorities.

We are not asking that new or refurbished facilities be luxurious, but construction and renovation are necessary for three reasons: 1) Inadequate facilities can impair productivity. For example, having too few examining rooms impedes physician efficiency, or having inadequate laboratory facilities may mean sending tests to other laboratories and require an additional patient visit when the test results return; 2) Community Health Centers should not appear to be "second class" health care if they are to be acceptable to their potential patients. This is particularly important as we look at prepaid and voucher modes of financing care; and 3) Adequate facilities imply a permanence and a commitment to Community Health Centers as important parts of the total health care system. Lack of permanent facilities has led providers, patients, and the general public to regard Community Health Centers as temporary.

VII. That health centers be permitted to use any income which exceeds operating costs to generate funds for development. (no references)

Projects are and should continue to be awarded grants based on projected reasonable costs, less projected reasonable income from state, local, other funds, fees, premiums, and third party reimbursements. However, projects are well aware that any savings they accrue through efficiency of program administration will be offset by a reduced grant in the following year. The present system reinforces a "spend it or lose it" mentality, project dependence on DHEW, and a feeling of transience.

We recommend that projects be permitted to retain savings they generate by either reducing operating expenses or increasing reimbursement. In other words, the following year's grant should not be offset by the amount of the excess income. This retention of a development fund would be the same

as that currently permitted HMO's and would provide additional incentive for efficiency.

Development funds would be restricted to expenditure on one of the following, as the project assessed its community's needs:

a) to increase the number of persons served

b) to increase the number or range of services provided.

c) to improve the quality of services.

d) to develop and maintain a reserve fund to be used in offsetting underestimates of funding needs for approved project activities, and for purposes of complying with state regulations for prepaid health care services.

e) to improve management and operational capabilities, including those related to the maximization of third party reimbursement revenues.

f) to constitute a capital improvements fund as a means of addressing the problem of inadequate facilities which inhibit productivity and acceptance of Community Health Centers as important and permanent parts of the total health care system.

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Mr. Chairman, the above recommendations refer to both Community and Migrant Health Centers. I would like to turn to those concerns which affect only the Migrant Health programs.

VIII. That eligible recipients include those migrant and seasonal farmworkers who can no longer meet the work requirement because of age or disability as well as members of their families. (Refer to Section 319(a)(2)(3)[1]).

Present definitions specify that agricultural workers must meet certain residence and work criteria in order to qualify for services. The present definition excludes workers who because of age or disability can no longer perform rigorous agricultural labor, therefore disqualifying themselves and their families from health benefits. Migrant and seasonal farmworkers receive minimal benefits under Medicaid and other third-party programs. They are thus particularly dependent on Section 319 and 330 programs.

IX. That the definition of "high-impact area" be changed from 6,000 migrant and seasonal farmworkers to 4,000 migrant and seasonal farmworkers. (Refer to Section 319(a)(5)[1]).

At this time, 125 grantees serve migrant and seasonal agricultural workers in 250 service sites. Many of these service sites are "projects" rather than "centers" because the present definition of "high impact areas" precludes their becoming "centers". "Projects" would benefit by becoming "centers" in that they would be required to offer a broader range of services and would be governed by a consumer-based board. Currently, a high impact area is an area which has not less than 6,000 migratory and seasonal workers. With 967 counties in the United States with migrant populations, less than 26% presently qualify as high impact areas.

By changing the number of workers needed to identify an area as high impact, a greater number of areas would be able to qualify to provide additional, improved services to the target population through migrant health centers. Quite frankly, our concern is that migrants away from home base areas receive more than just emergency care.

X. That a governing board be mandated for all Migrant Health Centers and Projects with no waivers permitted. (Refer to Section 319(c)(2),(d)(1)(B)[1]).

Community and migrant health centers have demonstrated that community boards maintain sensitivity to consumer needs, often taking into account factors frequently overlooked by traditional health providers, i.e. language, cultural attitudes. The active involvement of consumers also encourages the target population to accept new and innovative methods for delivering health services. Consumer involvement motivates users of the centers to determine for themselves how and when services in those centers should be offered.

In the previous legislation, up to two-year waivers were allowed for programs which the Secretary determined could not meet all of the requirements and conditions of Sections 330 and 319.

The biggest problem was meeting the governing board requirement by those traditional agencies which were reluctant to transfer policy making authority to consumer boards. Since that time, grantees have been forced into compliance with these requirements. As this transitional period has passed, we no longer see the need for such waivers. Accordingly, each applicant should meet the governing board requirement before receipt of grant funds.

XI. That special project authorization be limited to not more than 2% of appropriations. (Refer to Section 319(e)[1]).

Currently, up to 10% of the funds appropriated for operating grants may be used for contracts in the implementation and enforcement of environmental health standards. As funds for services are meager, we believe that the authorization should be reduced to 2%. While it is a worthwhile activity, we believe other programs could assume greater responsibility in this area if they were more adequately funded.

XII. That not more than 30% of the total funds be made available to projects in non-high-impact areas (Refer to Section 319(h)(1),(h)(2)[1]).

With respect to operating and planning and development grants, present legislation restricts allocation to non-high-impact areas to not more than 25% of the total or 90% of the previous year's grant. The real problem is a shortage of funds. However, in order to maintain the capacity of upstream programs, we believe that the allocation should be increased to "not more than 30% of the total funds."

XIII. That not less than 15% shall be used for hospitalization (Refer to Section 319(h)(3)[1]).

Hospital services, both inpatient and outpatient is an area which has not had adequate funding. In order to be effective in offering comprehensive services, inpatient and outpatient hospital services should not be less than 15%. We further believe that current legislation should specify that priority should be given to areas in which those services are not currently being provided.

XIV. That the National Advisory Council be strengthened

(Refer to Section 319(b)(g)[1])

While we understand that the National Advisory Council was created to advise the Secretary in matters regarding migrant health centers and other entities having grants and contracts under Section 319, we believe that the following powers and responsibilities should specifically include:

1. to recommend general policy
2. to review and advise on federal regulations and administrative recommendations relating to program policies and development
3. to review funding allocations to the regions and basis thereof
4. to review and advise federal initiatives which relate to activities performed under this Act.

We also believe all projects funded under this Act shall be advised and notified in writing of:

A. a listing of all advisory council members, and
B. copies of findings, reports and recommendations of the Council.

Mr. Chairman, I would like to turn now from the above recommendations to our proposed authorization levels.

XV. That authorization levels for fiscal year 1979 be set as follows:

- Community Health Centers $366,000,000
- Migrant Health $ 66,950,000

and for fiscal years 1980, 81, 82, and 83, an increase of 25% each year - (See Charts A and B (refer to Sections 330(g)(1), (g)(2), and 319(h)(1), (h)(2), and (h)(3)[1].

Mr. Chairman, we realize the concern of this Committee to
b bring about a closer proximity between authorization and appropriation levels. S.2474 would increase authorizations for 1979 by 10% per year. This is barely enough to offset inflationary costs, let alone expand the programs. You must recognize we cannot absorb increased costs for labor, malpractice insurance, and supplies. Many health center employees are unionized and the new minimum wage will have an impact. Inflation in the ambulatory health sector has remained at 9-11% in each of the last three years. While centers have been able to offset some of this in the past, most programs are approaching maximum efficiency. The option then, is to reduce services. I am sure this is not what you intend to happen

Mr. Chairman, I wish to extend to you our sincere thanks for your support and personal leadership in advancing the community and migrant health center programs. We are deeply indebted.

Should you have any questions, I would be happy to respond.

Recommended Authorization

Chart A: Community Health Centers

	FY 79	FY 80	FY 81	FY 82	FY 83
I. Support to on-going CHC's - fiscal 78 level of $247,000,000 adjusted for inflation at 10%	$271 m				
II. New Starts - Add 1,100,000 new patients at a per capita grant of $54 through 200 CHC's or $300,000 average grant	$ 60 m				
III. Initiatives: A. CHAP - would provide 10 new starts at $300,000 and an additional 150 pediatric & nurse practitioner staff for centers already at full capacity. It would also permit the outreach services crucial to the success of this program.	$ 10 m				
B. Adolescent Care - same as administration request	$ 15 m				
C. Construction and Renovation	$ 10 m				
TOTAL	$366 m	$457.5 m	$571.9 m	$714.9 m	$893.6 m

Chart B Recommended Authorization

Migrant Health Programs

		FY 79	FY 80	FY 81	FY 82	FY 83
I.	On-going support - to fund the existing 125 grantees with 10% for inflation.	$37.95 m				
II.	New Starts - to fund 80 new starts at $200,000 each. To serve an additional 262,295 farmworkers at the current cost of $61/person.	$16 m				
III.	Initiatives or New Programs	$13 m				
	A. Hospitalization - $3 m It is our belief that the present $3 m appropriation for hospitalization must be raised to $6 m to offer more adequate services. Presently only 1/10 of 1% of the target population is being served.					
	B. CHAP - $4 m This figure would provide for additional pediatric & nurse practitioners (150) which would be required for centers already at full capacity in high impact areas and/or for satellite activities in adjacent areas. *President's budget implies funds are targeted for CHAP services. This is not true.					
	C. Adolescent - $2 m This figure would provide comprehensive health services for adolescents (projected 19,550) especially pregnancy, veneral disease, drug & alcohol abuse, and emotional disorders.					
	D. Demonstration - $2 m This figure would allow for the maintenance and expansion of prepaid plans, such as those currently in operation, El Valle, Laredo and East Coast. The amount would provide coverage for at least 10,800 migrant workers/family members at $185 per person.* *figure computated from FY 76 at $139 per person inflated and compounded annually for 3 years.					
	E. Construction and Renovation - $2 m					
	TOTAL	$ 66.95 m	$ 83.69 m	$104.61 m	$130.76 m	$163.45 m

COMMUNITY HEALTH CENTERS

CHART C

PROGRAM ACTIVITY

Community Health Centers

	FY 74*	FY 75*	FY 76**	FY 77*	FY 78(est)*	FY 79(proj)*
1. Funding Level (BA) (in millions)	$ 196.7	$ 196.7	$ 196,648	$ 215.15	$ 247.0	$ 286.0
2. Total Projects	157	204	302	455	574	705
(a) CHCs	157	-	-	158	158	158
(b) RHIs	-	-	-	262	356	441
(c) UHIs	-	-	-	35	60	106
3. Number of Persons Served	1,235,000	1,425,000	2,539,160	3,424,000	4,565,000	5,604,059
4. Number of Encounters	5,600,000	6,555,000	9,984,304	12,612,600	17,376,500	21,640,560
5. Total Cost Per Person Served	$238	$204	$129	$108	$100	$96
6. Grant Funds Per Person Served	$159	$138	$ 75	$ 62	$54	$51
7. Total Funds Available	-	$290,648,000	$327,282,000	$370,944,827	$457,407,407	$539,622,642
(a) Third-Party	-	$ 62,000,000	$ 93,685,000	$114,992,896	$160,092,592	$194,264,151
(b) Other	-	$ 32,000,000	$ 36,949,000	$ 40,803,931	$ 50,314,815	$ 59,358,491
8. Cost Per Encounter (Total)	-	$44.30	$33.00	$29.40	$26.30	$24.90
9. Cost Per Encounter (Grant)	$35.00	$30.00	$20.00	$17.00	$14.00	$13.00

* Budget Justification -Revised April 15, 1976

**Justification of Appropriation FY 78 DHEW/HSA

MIGRANT HEALTH

PROGRAM ACTIVITY

Migrant Health

CHART D

	FY 75*	FY 76**	FY 77*	FY 78(est)*	FY 79 (proj.)*
1. Funding Level (BA) millions	$23.75	$25.0	$30.0	$34.5	$34.5
2. Total Projects	105	97	125	138	138
3. Number of Persons Served	390,000	400,000	499,000	557,000	557,000
4. Number of Encounters	640,000	800,000	998,000	1,114,000	1,114,000
5. Total Cost Per Person Served	$100	$98	$94	$96	$96
6. Grant Funds Per Person Served	$ 61	$63#	$60	$62	$62
7. Total Funds Available	$39,000,000	$39,000,000	$47,000,000	$53,000,000	$53,900,000
(a) Third Party	-	$ 3,120,000	$ 3,800,000	$ 4,300,000	$ 4,300,000
8. Cost Per Encounter (Total)	$61.00	$49.00	$47.00	$48.00	$48.00
9. Cost Per Encounter (Grant)	$37.00	$31.00	$30.00	$31.00	$31.00

Incorrect figure by HSA

* Budget Justification - Revised April 15, 1976

** Justification of Appropriation FY 78 DHEW/HSA

Senator JAVITS. Our next witness is Basilio Romero, executive director of RANCHO, Inc. of Seattle, Wash. And may we ask you, Mr. Romero, if you would be kind enough to summarize your statement, and it will all be included in the record.

STATEMENT OF BASILIO F. "TOM" ROMERO, EXECUTIVE DIRECTOR, RANCHO, INC., SEATTLE WASH.

Mr. ROMERO. I will. Thank you, Mr. Chairman. I would like to thank you for the opportunity to appear before you today and submit this statement. I will summarize this statement, which is a compilation of concerns of several community health organizations located throughout the country; farm labor advocates, as well as those that are part of the coalition of RANCHO.

We are especially grateful to the migrant legal action program, and the other agencies, such as Rural America, for their assistance in preparing this statement. RANCHO and the farm labor advocates greatly appreciate the strong commitment of the subcommittee and its chairman for the cause of migrant health.

This commitment has led to the creation and maintenance of very efficient migrant health centers since the program's inception in 1962. We agree with some of the statements made by Dr. Davis in relation to the community-based programs, and so forth. I will not elaborate on that. However, I would like to zero in on some of the constraints that are particular and specific to migrant health; namely, the inadequate, current funding for farmworker health.

The current funding meets between 22 and 28 percent of the health needs of farmers, which results in approximately 29 counties in 6 States, with a 6,000 or more farmworker population, unserved by migrant health facilities. Twenty of these counties are also unserved by the more urban-oriented community health centers.

Our proposal is that full ambulatory care service to the Nation's eligible farmworkers and dependents requires between $65 and $95 million. Providing adequate hospitalization coverage requires at least an additional $60 million. These unmet needs will not likely be addressed outside the Migrant Health Act. We urge the subcommittee to accept a figure of $125 million, as a threshold cost for minimal adequate migrant health care, and to adopt that figure as a funding goal.

It is not unrealistic to augment the migrant health program in $15 million annual increments for the next 6 years in order to reach that threshold in health delivery by 1984.

We just heard from HEW when they talked about capacity building programs. This is not the case with respect to migrant health as it relates to a comprehensive system of health care for farmworkers under this act. One of the pressing and most urgent issues in terms of migrant health is the continuing HEW attempt to divert scant moneys from migrant health programs into a "consolidated" health care delivery package as part of the rural health initiative program.

When we talk about our objection to rural health development, we are not talking about the areas outside of the agricultural community. We do support, in principle, the theory and the approach of the rural

health initiative program. However, we believe that the problems of migrants are unique to warrant special legislation.

Presently, the lure of the rural health initiative program is enough to tempt even the most conscientious administrator. By pooling moneys from various small and specialized programs, an administrator could develop a large, unified, and comprehensive program. An RHI, so the argument goes, can provide a greater variety of services to migrants over a more continuous period.

The consolidation theory does not match its reality. Draining money from a rural migrant health project into a semi-urban health center has many adverse effects. It becomes inaccessible, a bilingual staff, which has been effective in serving the farmworker, becomes dispensable. Health outreach efforts, which have been so crucial to the success of migrant health projects, become costly frills to the semi-urban center.

We urge that HEW must not divert scarce migrant health resources to large community health enterprises, in a cavalier hope that migrants will continue to receive a fair share of health services. Indeed, the fundamental premise underlying the Migrant Health Act of 1962 is "In recognition of the failure of existing private health services or Government programs to provide adequate health service to the Nation's migrant farmworker."

Another issue that I would like to zero in on is in respect to the inpatient hospital needs. We heard from HEW that they are proposing a change in their residency requirement to allow for more participation in medicaid. Well, $3 million, the current moneys available for inpatient care, is hardly enough to meet the needs of farmworkers. The best estimates that we have—HEW estimates—are that current levels defray less than 5 percent of the migrant hospitalization needs each year. We propose an increase to at least $6 million

Another issue which is of great concern to the migrant health centers is the definition of "high impact area." This issue, as it relates to capacity building, as migrant health centers gradually expand into unserved areas, the 6,000 migrant/2 month funding formula may become unnecessarily restrictive. We suggest, therefore, that Congress delete the formula and retain its principle in the general language of subsection (b) (1). This would enable HEW to continue funding those established farm worker health facilities that have developed efficient cost-effective program services, specifically oriented at meeting the needs of farmworkers.

For example, the United Health Centers of San Joaquin County in Orange Grove, Calif., which serves a large farmworker population in Fresno County, has been faced with cutbacks because of the definitional change of migrant to seasonal farmworker. The demand for services, however, increases or remains the same from the same population. We believe that seasonal farmworker subjected to the same working environment as a migrant is also faced with the same barriers to health care.

The funds that were secured by the health centers, for example, to maintain the level of services were not new moneys to be used for meeting increased demand for services from the farm worker population. This kind of disruption precludes the development of a com-

prehensive health care facility in a planned, orderly, and progressive manner.

Mr. Chairman, I would like to also cite the issue of coordination. We have heard consolidation, in terms of pooling moneys, but we have not heard about consolidating these programs that serve farm workers which should be part of a total comprehensive package for farm worker health delivery systems. We believe that the reauthorization bill can provide the necessary impetus for interagency cooperation.

The other concern we have is the National Advisory Council on Migrant Health—we recommend that it be retained and that the authority and role of the National Advisory Council for Migrant Health be expanded. One of the modifications that we would like to see made is that the selection process be changed to assure maximum input from migrant health centers.

Mr. Chairman, I want to thank you for being here. In closing, we feel that comprehensive health care is a fundamental right of every farmworker. Our professional goal for migrant health is to see that HEW—BCHS, in particular—and this Nation is fully committed to an integrated comprehensive health care system for the more than 5 million farmworkers in this country. Thank you very much.

Senator JAVITS. Thank you very much, Mr. Romero.

[The prepared statement of Mr. Romero follows:]

STATEMENT TO SENATE SUBCOMMITTEE ON HEALTH
AND SCIENTIFIC RESEARCH

RE: HEALTH SERVICES EXTENSION ACT OF 1978

Mr. Chairman and members of the Subcommittee, my name is Basilio F. Tom Romero, Executive Director of Rancho, Inc. I would like to thank you for the opportunity to appear before you today and submit this statement on S.2474, a bill to reauthorize the Migrant Health Programs under the statutory authority of Title 42 U.S.C. § 247d.

The Regional Associations of non-profit Community Health Organizations is a coalition of the Northwest Chicano Health, Inc., the California Rural Health Federation and the Rio Grande Federation of Health Centers.

The membership of the three Federations total 93 migrant and rural health centers and clinic sites which are located throughout the states of Washington, Oregon, Idaho, California, Arizona, New Mexico and Kansas. They represent health care entitlement to the more than 734,835 migrants and 1,451,402 seasonal farmworkers that reside in those areas.

We are grateful to Migrant Legal Action Program, Inc., for their assistance. MLAP is a Legal Services Corporation support center located in Washington, D.C., that provides assistance to farmworker clients, client groups, attorneys

and other farmworker representatives located in over 130 offices in 29 states. They also engage directly in litigation or other advocacy on behalf of farmworker clients.

Rancho and farm labor advocates greatly appreciate the strong commitment of the Subcommittee and its Chairman to the cause of migrant health. This commitment has led to the creation and maintenance of very efficient migrant health centers since the program's inception in 1962. Our criticism of the program is its inadequate level for meeting the health care needs of the more than five million farmworkers in this country.

Presently, less than one-quarter of the health needs of farmworkers and their families is met by this program for eligible population of 700,000 migrants and two million seasonal farmworkers and their dependents.

Three examples will suffice. Last year in Arizona a migrant suffered a permanently broken thumb when his migrant status caused a denial of medical attention from the county hospital. Last year in central California a seasonal farmworker was advised by his physician to undergo hospitalization for pneumonia but was denied admission for several days because he was medically uninsured; he was ultimately admitted under threat of a lawsuit. Last year the minor son of a migrant worker was denied hospital care for a cardiac problem in Colorado because of his suspected illegal alien status. The boy was shipped to Mexico where he died for lack of

prompt medical attention. These three incidents reflect problems common to all farmworkers. All three incidents occurred in communities having efficient but meager migrant health facilities. And all three incidents arose from health care gaps generic to the migrant population.

We urge the Subcommittee to consider the following in their deliberation regarding the reauthorization of the Migrant Health Program:

1. Minimally adequate health care for the migrant population requires funding at $125 million.

2. A separate program for migrant health. Consolidation Means Dilution; require that HEW fund programs through Section 319 only.

3. Support services be an integral part of the service delivery mode of a migrant health center and that funding be flexible to allow for development of alternative approaches for providing health care.

4. Coordination among federal agencies that provide health care for migrants and their families.

5. Increase In-Patient Hospitalization Funds.

6. Definition of High "Migrant Impact". On new starts, priority be given to areas with the greatest number of migrants. That established centers that serve farmworkers be able to maintain their level of funding from 319 funds in the event their "high impact" status is changed. Priority funding be given to established migrant health centers and community based organizations.

7. Retain the National Advisory Committee on migrant health except to modify the selection process to assure the migrant health center more input in who gets selected.

8. Require that services be comprehensive and that they be consistent with the language, cultural and ethnic backgrounds of the migrants to be served.

1. Minimally adequate health care for the migrant population requires funding at $125 million.

This Subcommittee surely appreciates the chasm between existing migrant health services and actual migrant health needs. By HEW population surveys, over 1.7 million farmworkers and dependents -- two-thirds of the farmworker population -- remain medically unserved.

The largest farmworker home-base areas such as Hidalgo County, Texas, Fresno County, California, and Collier County, Florida, continue to be designated medically underserved areas. Twenty-nine counties in six states* each have migrant and seasonal farmworker populations exceeding 6,000, and yet are totally unserved by migrant health facilities. Twenty of these counties are also unserved by the more urban-oriented community health centers.

Providing full ambulatory health service to the nation's farmworkers and dependents requires between $65 million and $95 million; providing adequate hospitalization coverage requires at least an additional $60 million. Thus, current funding reaches from 22 to 28 per cent of the minimum medical needs of the target population.

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* California, Florida, Michigan, New Jersey, Oregon and Texas.

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These unmet needs will not likely be addressed outside the Migrant Health Act. We urge the Subcommittee to accept the figure of $125 million as the threshold cost of minimally adequate migrant health care, and to adopt that figure as a funding goal. It is not unrealistic to augment the Migrant Health Program in $15 million annual increments for the next six years in order to reach that threshold in health delivery in 1984.

2. Consolidation Means Dilution.

The most urgent migrant health issue facing this Subcommittee is the continuing HEW attempt to divert scant monies from the Migrant Health Program into a "consolidated" health care delivery package as part of the Rural Health Initiative (RHI) program.

The Rural Health Initiative Program has been instituted in HEW by the Bureau of Community Health Services by combining various elements of rural health care, including migrant health money, into larger integrated units. Initial grants for RHI have gone to areas of low-population density and high numbers of poor or elderly citizens, and low physician-patient ratios. In fiscal 1977, HEW set aside $4.5 million which Congress had appropriated for migant health and instead earmarked this money for the Rural Health Initiative Program. Although only $1 million of this money was used actually to fund RHI projects, HEW has set aside another $4.5 million for migrant health money for RHI projects in fiscal 1978.

The lure of RHIP's is enough to tempt even the most conscientious Administrator: By pooling monies from various small specialized programs, an Administrator could develop a large, unified and comprehensive program. An RHI, so the argument goes, can provide a greater variety of services to migrants over a more continuous period.

The consolidation theory does not match its reality. Draining funds from a rural migrant health project into a semi-urban health center has many adverse effects. The rural health project located next to a grocery store in a small town moves 30 miles away to a shopping center in a small city and thereby becomes virtually inaccessible to migrants. The bilingual staff which had been so effective in servicing the farmworker population becomes dispensible in the larger semi-urban operation. Health outreach efforts which had been so crucial to the success of the migrant health project become costly frills to the semi-urban center.

These fears are not fanciful. Time and again migrant health providers related situations like that in one area of the Eastern Seaboard where a migrant health center and an RHI project operate in the same area. The RHI tends to ignore community education and bilingual outreach, and instead fosters a pervasive attitude of treating local residents first, and migrants second, if at all.

HEW must not divert scarce migrant health resources to larger community health enterprises in the cavalier hope that migrants will continue to receive a fair share of health services. Indeed, the fundamental premise underlying the Migrant Health Act is "In recognition of the failure of existing private health services or government programs to provide adequate health services to the nation's migrant worker."

First, HEW must assure that a fair percentage of community health centers under Section 330 are located in rural areas. Second, HEW must reverse its direction by assuring that rural groups and migrants receive their fair share of a myriad of other programs which historically are absorbed by urban areas. These programs include Maternity and Infant Care, Children and Youth, Family Planning, HUVA Community Health Centers, Hypertension, National Health Service Corp., and Title I, Migrant Education, and that HEW should assure the delivery of some of these resources to migrant health in supplement of existing migrant health programs.

We urge the Subcommittee to preclude HEW from draining migrant health resources into consolidation adventures. If such a preclusion is impossible, then at the very least the following safeguards must be imposed:

(a) that HEW's consolidation plans be considered "experimental" subject to a prudent annual dollar sealing and subject to annual reporting to Congress;

(b) that migrant health funds be available to an RHI program only in areas where the migrant population is significant enough that it merits service but small enough that no separate migrant health facility is feasible;

(c) that any RHI program using migrant health resources strictly report to HEW on the nature and extent of services provided to migrants and their dependents; and

(d) that governing boards of such RHI programs have migrant representation in porportion to the number of migrants in the target population selected under procedures materially similar to those applicable to the governing boards of migrant health centers.

3. Support Services are Vital.

HEW is reluctant to fund migrant health projects for social services outside the direct delivery of health care, in order to conserve the scant resources available. This reluctance causes problems in many remote areas, however, where certain support services are crucial to the success of a migrant health project. These services include outreach, the transportation of workers to the project from labor camps, adequate community education or special provisions for bilingual staff.

HEW's chary approach causes projects to hide support service costs in their administrative budgets, which itself creates problems in a grant review. We urge Congress to make it clear that a budgetary item for support

services must be funded by HEW to the extent that any such service is necessary to provide effective health care delivery to the target population, and must be weighed on its merits with respect to any grant proposal.

4. Coordination Among Federal Agencies.

Federal agencies having money available for farmworker health frequently lack cooperation. Several programs invite integration into migrant health, such as the Women, Infants and Children Feeding Program (WIC, Department of Agriculture); the Pre-Screening and Record Transfer System under Title I of the Migrant Education Program (HEW); health money under the Comprehensive Employment and Training Act (Department of Labor); and money for rural transportation (Department of Transportation).

These programs offer financial resources which have not been used. For example, some $450 million earmarked for rural transportation exists within the Department of Transportation; although this fund goes to capital purchases rather than operating expenses, it could underwrite the cost of a modest migrant transportation system for many health projects. A National Record Transfer System already is in place under the Migrant Education Program, whereby a child's school records are stored on a central computer and are easily available to any school

in which the migrant child is subsequently placed. Adaptation of this existing network for storage of migrant health records must be explored.

Accordingly, the reauthorization bill can provide the necessary impetus for inter-agency cooperation. The bill should require HEW to develop a plan to coordinate the activity of each federal agency performing statutory function with respect to migrant health, in order to assure the maximum level of health care delivery. Coordination must include the Office of Migrant Education, the Office of Child Development, the Employment and Training Administration, the Food and Nutrition Service, and the Department of Transportation, and to submit the plan to Congress within eighteen months thereafter.

5. In-Patient Hospitalization Needs.

HEW currently earmarks about $3 million annually to meet the in-patient care needs of the nation's farmworker population. HEW understandably does not wish to dissipate its scarce resources by underwriting an elaborate health care program which diverts monies to private hospitals and physicians without adequate cost controls.

Nonetheless, migrant hospitalization remains as a critical unmet need. HEW estimates that current levels defray less than 5 per cent of migrant hospitalization needs each year.

For example, in Northern Santa Barbara County, California, farmworkers are deprived of minimal health care even though they live in an area having two private hospitals and one county hospital. They have no health care plan provided through their employment. Eligibility for Medicaid (called "Medical" in California) is unavailable to any household whose head is employed more than 100 hours during the month -- a provision excluding virtually all farmworker families during the nine to ten month season. The county hospital which normally provides services to indigents having no public or private insurance repeatedly refuses to assist migrant workers because they are not considered "residents" for whom the county has a legal obligation of care. Although one of the two private hospitals had received federal construction funds under the Hill-Burton Act, it consistently refuses to honor any obligation under Hill-Burton to provide services to indigents. The sad upshot is the repeated exclusion of farmworker families from adequate hospital care although they reside in a medically well-served area.

In Colorado, a farmworker must travel to Colorado General Hospital in Denver from any other point in the state in order to receive in-patient care. In Oregon, other hospitals deny care to migrants on the premise that the University of Oregon Hospital in the Northwestern corner of the state is available to service migrants. Common

medical needs among migrants and their dependents during the season include pneumonia, tuberculosis, polio, arm and leg injuries and maternity care.

6. Definition of "High Impact Area".

Subsection (d)(1)(C) provides for funding of projects in areas in which not more than 6,000 migratory agricultural workers and their families reside for more than two months. We agree with this concept especially for new starts. We also suggest that this concept is sufficiently set forth in Subsection (b)(1) requiring funding priorities in "areas in which reside the greatest number of migratory agricultural workers and the members of their families for the longest period of time." HEW should be authorized to fund, if otherwise appropriate, a project covering 4,000 migrant workers and dependents over a six-month season. Alternatively, HEW should be authorized to fund, without restriction, a state-wide program having considerable numbers of migrants but who are dispersed among numerous small pockets in the state.

As migrant health gradually expands into unserved areas, the 6,000 workers/two-month funding formula may become unnecessarily restrictive. We suggest, therefore, that Congress delete the formula and retain its principle in the general language of subsection (b)(1). This would enable HEW to continue funding those established farmworker health facilities that have developed efficient cost

effective program services specifically oriented at meeting the needs of migrants.

For example, United Health Centers of San Joaquin County, Orange Cove, California which serves a large farmworker population in Fresno County, has been faced with cutbacks because of the definitional change of migrant to seasonal farmworker.

The demand for service, from that same population, remains the same and often increases, a population whose needs for health care is unchanged despite the definitional reclassification.

The funds that the were secured by the United Health Centers to maintain the same level of services were not "new" monies to be used for meeting the increased demand for services from the farmworker population. This kind of disruption precludes the development of a comprehensive health care facility in planned, orderly and progressive manner.

7. National Advisory Council for Migrant Health.

In order to insure accountability and responsiveness to farmworkers in this Nation, we recommend the retention and expansion of the authority and role of the National Advisory Council for Migrant Health (NACMH).

1. Modify the selection process to assure maximum input from migrant health centers.

2. NACMH should be recognized as the central focal point for dialogue with HEW and the farmworker community.

3. NACMH should be provided the necessary staff to facilitate an ongoing planning, review and oversite capability.

4. NACMH should be provided resources to conduct four (4) Regional Meetings per year in order to assess the effectiveness of HEW's efforts on behalf of farmworkers in the Health Services.

5. NACMH should provide an independent assessment each year of the progress of HEW's total effort in farmworker health services to the Secretary of DHEW.

6. In order to ensure representation of farmworkers throughout the Nation NACMH should be composed of active migrant and seasonal farmworkers from each of the ten (10) federal regions selected by farmworker-governed health projects within each Region, five (5) representatives from various health professions and occupational areas, and a representative from Migrant Division of BCHS and a representative from the Secretary.

7. This advisory council should be concerned with existing farmworker programs, and also be the vehicle for input to any National Health Insurance program, as it is refined and implemented in the next year or two.

In closing, we feel that comprehensive health care is a fundamental right of every farmworker. Our professional goal for migrant health is to see that HEW/BCHS and this notion is fully commited to integrated comprehensive health care system for the more than five million farmworkers in this country.

Senator JAVITS. Our next witness is Dr. James Block of the Genesee Hospital in Rochester, N.Y. Would you, Dr. Block, summarize your statement within 10 minutes.

STATEMENT OF JAMES A. BLOCK, M.D., DIRECTOR, AMBULATORY SERVICES DEPARTMENT, GENESEE HOSPITAL, ROCHESTER, N.Y., AND DIRECTOR, COMMUNITY HOSPITAL-MEDICAL STAFF SPONSORED PRIMARY CARE GROUP PRACTICE PROGRAM, ROBERT WOOD JOHNSON FOUNDATION

Dr. BLOCK. I am Dr. James Block. I am director of ambulatory services at the Genesee Hospital in Rochester, N.Y., and I am also the director of the Community Hospital-Medical Staff sponsored primary care group practice program of the Robert Wood Johnson Foundation. I am here today to testify as an individual in support of the amendment to the Community Health Center Act introduced by Senator Javits which would permit the funding of community hospitals to establish primary care centers.

I thought that the most effective way for me to indicate my support for this amendment would be to share with you the experience that we have had in Rochester, N.Y., at Genesee Hospital in establishing a primary care center. I would add parenthetically that we have received support through HEW's Community Health Centers grant to the Rochester Health Network to establish this primary care center.

We initiated this effort in 1970, because we were facing problems which were similar to those seen throughout the United States. We had an increasing demand in our emergency department by patients who, in essence, were unable to find physicians in their neighborhood. Not only did we find total visits to our emergency department increasing, but it was our impression that the percentage of visits to our emergency department by nonemergent patients was also increasing.

We estimated that as many as two-thirds of the patients who came to our department were nonemergent and were there because they were seeking primary care services. In addition, we saw similar increases in the outpatient clinic of our hospital. We looked at the visit data which these patients generated and we found some very interesting figures.

We found that those patients who were coming to our emergency department three or more times—and we felt that this indicated they were looking to the department as their source of care—that over half of those patients were medicaid recipients. In addition, those patients were also using our outpatient clinic. We found, in our outpatient clinic, 5,000 patients who were using both the emergency department and the outpatient clinic, who had made a total of 25,000 visits to the hospital.

We also found a very interesting group of patients that I would mention. One thousand patients who used the emergency department and the clinic made a total of 17,000 visits in 1 year; once again the majority of these patients were medicaid recipients. I would like to qualify that, however, with one very important observation. We

found that black patients who utilized our emergency department three or more times did so regardless of the source of payment for their care. What this indicated to us was that it was not only the low-income patient in our community who was relying on the emergency department as a regular source of medical services.

I would like to speak for a moment about our outpatient clinic. It was organized as other traditional outpatient clinics in this country are organized. We had 33 different specialty clinics. We had no appointment system, which meant that patients normally appeared at 8 in the morning and might not be seen for several hours, or they appeared at 1 in the afternoon and might still be there at 5:30.

Patients did not have their own physician; there was no one coordinating their care. The clinic charge was expensive; the collections were abyssmal. The facilities were inadequate, and in the last analysis, a system of care had evolved incapable of responding to the medical needs or basic dignity of the patient.

We asked ourselves what might be a more appropriate response of a hospital to demands for on-going medical care being made upon it by low income and other patients in our community who were turning to us. At Genesee, we made the decision to close our outpatient clinic entirely. We felt that a necessary first step was to rid ourselves of the concept. We reminded ourselves that the outpatient clinic was the only department within the hospital which was intended to serve one socio-economic class. We felt it was inappropriate for a hospital to house a service that was defined in this manner.

Having made a decision to close the clinic we decided to establish at our hopsital a group practice for the delivery of primary care. The objective of the primary care center was to serve all patients, regardless of income, socio-economic status, or race. We wanted to move the concept of outpatient care to one of serving all patients in the community in need.

Second, we felt it was critically important to organize the service so that we would have success in recruiting and, more importantly, retaining excellent physicians. We were well aware of the difficulties that were inherent in establishing new programs in urban areas; the difficulties that were reflected primarily in their inability to recruit and retain physicians.

Third, we wanted to have community involvement in the entire process. We worked with organized community groups located near the hospital. They participated with representatives of the hospital board in planning the transition. They also formed an ongoing advisory board to the group practice, made up of consumers, as well as hospital representatives and physicians.

I would now like to summarize our experience since closing the outpatient clinic in 1970. At that time the outpatient clinic was serving 80 percent medicaid recipients. There were approximately 25,000 visits a year. Today, our medical group practice consists of 15 fulltime physicians. We are seeing approximately 100,000 patient visits a year. Medicaid patients make up about 45 percent of the visits to our medical practice. However, I would emphasize that we have increased the number of medicaid patients cared for at our institution fourfold in the process, and substituted 24-hour, 7-day telephone coverage for many former ED or OPD visits.

Today our hospital is one of the major providers of care to our state's medicaid patients outside of New York City. I would also like to emphasize that our cost for providing comprehensive primary care to medicaid patients is comparable to our community's private sector fee structure.

It is also important to know that our primary care center essentially runs as an organized medical group; that each patient has his/her own physician; that we have an appointment system; that we have physicians on call 24 hours a day; that we have office hours 6 days a week; that we have evening office hours at least 4 days a week.

I would also like to mention two other critical points that fall into the area of financing. First, we have a prepayment plan which we offer in the community, both a Blue Cross plan and a medicaid plan, and patients come to the group whose care is financed through these plans. Second, one of the problems we have faced in further reducing our costs for care has been the result of medicare reimbursement policies which result in the allocation of excessive costs to our out-patient activities.

Certain cost accounting requirements and cost allocation requirements of the medicare program make it unnecessarily difficult for hospitals to reduce to the lowest level the cost of outpatient care. If the legislative intent is to enhance the role of hospitals in ths provision of ambulatory care, the existing regulations must be re-evaluated. Before concluding my remarks, I would like to also mention that I presently have the honor of directing a national program for the Robert Wood Johnson Foundation, directed at establishing primary care centers at community hospitals throughout urban and rural areas in the United States. I regret that your interest in our past achievements at Genesee Hospital coupled with the need for brevity have prevented me from sharing with you the importance and excitement of this effort by private philanthropy.

To date, the Robert Wood Johnson Foundation program has funded over 45 such hospitals, and we are very pleased with the results of that program. Many of these hospitals are pursuing the same kinds of concerns that Senator Javits reflected in his earlier statements; that is to say, they also are facing increasing demand in their emergency departments and are realizing the inadequacies of their outpatient clinics, as traditionally conceived, and of their emergency departments to effectively address the problems.

Three years ago, The Robert Wood Johnson Foundation announced a national grant program designed to assist community hospitals and their medical staffs strengthen the institution's role in ambulatory care by developing primary care group practices. This program was designated the community hospital-medical staff sponsored primary care group practice program. The announcement followed a 3-year examination of the role of community hospitals in ambulatory care and an assessment of the impact of pilot hospital-sponsored group practices throughout the country.

The Foundation committed $30 million to support as many as 60 hospital-sponsored group practices. Grant awards of up to $500,000 have been made available to each participating hospital to offset

planning and operating deficits of the new practices over a 4-year period. With this level of management, the program has become the largest single effort of the foundation to expand public access to primary care.

Nine hundred of the country's nearly 6,000 community hospitals—in all 50 States and the District of Columbia—were invited to submit applications that would meet the requirements set forth in the program's protocol. Almost half of these hospitals formally indicated interest in the program, and more than 200 completed applications were received. Between March of 1976 through December of 1977, 42 grants have been awarded to hospitals in 34 States. Total grant awards exceed $20 million. It is expected that additional grants will be awarded during 1978, primarily in the remaining 16 States.

In January of this year, 31 of the 42 funded group practice programs (74 percent) were in operation and providing primary care services. Resourceful and innovative hospital and medical staff leaders have developed practices which vary with regard to location relative to the hospital, populations served, organizational structure, staff composition, leadership dynamics, and facility design; 13 practices are located within their sponsoring hospitals or in professional office buildings on or near the hospital grounds; 14 others are housed in satellite locations in communities as far as 25 miles from the hospital. The remaining four operational projects have hospital-based facilities and one or more satellites. About half the practices are located in metropolitan areas; the remainder are evenly distributed between suburban and rural sites. Community economics range from middle-to-upper-income neighborhoods to low-income and poverty areas.

Senator JAVITS. Thank you very much, Dr. Block. I am very proud that a New York hospital in my State is engaged in such innovative procedures. Your experience is terribly helpful to what I have proposed. Again, I repeat, as I said to Dr. Davis, we will be scrupulous to see that this is not at anyone's expense—the community health centers, or anybody else's—but really operates on its own and is simply a methodological way to facilitate what obviously needs to be done.

I will not ask you any further questions now, but we will feel free, if we choose to, to write to you and, without objection, include whatever reply you make for the record.

[The prepared statement of Dr. Block follows:]

TESTIMONY BEFORE THE

SUB-COMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH OF THE UNITED STATES SENATE

James A. Block, M.D.
Director, Ambulatory Services Department, The Genesee Hospital, Rochester, New York
and
Senior Program Consultant and Director, Community Hospital-Medical Staff Sponsored Primary Care Group Practice Program of the Robert Wood Johnson Foundation

February 9, 1978

I am Dr. James Block, Director of Ambulatory Services at the Genesee Hospital in Rochester, New York. I also serve as a Senior Program Consultant to The Robert Wood Johnson Foundation of Princeton, New Jersey and as Director of the Community Hospital-Medical Staff Sponsored Primary Care Group Practice Program of The Robert Wood Johnson Foundation.

I am here today to testify as an individual in support of Senator Javits' amendment to the Community Health Center Act which would establish hospital affiliated primary care centers in medically underserved areas.

For the past seven years we at The Genesee Hospital in Rochester, New York have been actively involved in the development of a hospital affiliated primary care practice designed to meet the needs of an urban medically underserved population. Like many other hospitals we had experienced a rapid rise in utilization of our emergency department and outpatient clinic as patients unable to find family physicians turned to the hospital as their source of care. National data substantiate this trend. Fewer than 10 million emergency visits were reported by all community hospitals in the United States in 1954, more than 62 million in 1973. A large number of these visits are made by patients with problems that do not fit the conventional definition of a medical emergency; to a great extent they represent patients who rely on the emergency department as their "family doctor." Similarly, there has been a fourfold rise in the volume of outpatient visits to community hospitals in the last two decades, from 42 million in 1953 to 180 million in 1973. On an average day, 87,000 people are admitted as inpatients to community hospitals, while each day nearly half a million people come to the clinics and emergency rooms of these hospitals for treatment, tests and advice.

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Today I would like to share with you the experience we have had at The Genesee Hospital in our efforts to improve the care provided to patients who were seeking care through our outpatient clinics and emergency department. In addition to my work in Rochester, I have also had the opportunity to address these problems in other areas of the country through my work with the Robert Wood Johnson Foundation. In 1975 the Foundation initiated a $30 million national program designed to strengthen the role of community hospitals in ambulatory care by developing affiliated primary care group practices. Our experience with this program will also be discussed during my testimony.

I anticipate submitting a more extensive written statement to the committee subsequent to my testimony.

Senator JAVITS. Now, Dr. Kerr, could we hear from you, and would you be good enough to brief your statement to 10 minutes.

STATEMENT OF LORIN E. KERR, M.D., M.S.P.H. DIRECTOR, DEPARTMENT OF OCCUPATIONAL HEALTH, UNITED MINE WORKERS OF AMERICA, AND MEMBER, STEERING COMMITTEE, RURAL HEALTH COUNCIL OF RURAL AMERICA

Dr. KERR. I fully support your proposal to expand the funding available to local communities through section 330 and 319 programs, and to expand the range of primary supplemental and environmental health services that can be furnished through migrant and community health centers, and other community-based institutions.

I am particularly pleased to see the special concerns expressed by the sponsors of this legislation with the prevention of disease and disability, and the recognition of the importance of prevention as a part of a comprehensive community health services program. I feel strongly that any existing or new national health care system must emphasize priority for the complete range of preventive health measures, including occupational health.

While the community health center program has demonstrated its effectiveness in meeting the acute health care needs of people in medically underserved areas, the experience to date demonstrates at least three major deficiencies. Briefly, they are, (1), limited funding; (2) restrictive funding requirements; and, (3) a serious imbalance in the allocation of funds between urban and rural medically underserved areas.

The funds made available under the community and migrant health center programs have been wholly inadequate, in view of the magnitude and scope of the health programs confronting our medically underserved population. I strongly urge that we recognize the serious shortcomings of proceeding along the lines of what I would characterize as a medigap approach to meeting this society's health needs, and begin to move in the direction of extending a full range of needed medical and health services to all individuals who are currently excluded from our health care service.

As presently administered, the community health center program is concentrated on the provision of a comprehensive range of primary health care services, neglecting important supplemental and environmental services. By mandating a provision of specified primary care services, many smaller rural communities have been denied access to CHC funds because of their inability to provide all of the required services. This "all or nothing" approach has seriously restricted the development of community health centers in rural areas.

Additionally, the exclusive focus on primary care services has worked to the real disadvantage of many rural communities whose serious health problems are closely linked to inadequate domestic water, sanitation facilities, poor housing, and malnutrition.

In recent weeks, increasing attention has been paid to the numbers of health centers which have been developed in urban and rural areas. I have seen, for example, reports which show that more than

65 percent of the community health centers financed under the Section 330 program operate in rural areas, leaving the clear impression that only limited attention has been paid to urban health.

According to a recent report prepared by Rural America, roughly 75 percent of the comprehensive community health centers, accounting for more than 80 percent of the funds, were located in the cities. For example, of the 158 centers funded in 1977, 122 operated in urban areas, and 36 centers, or less than one-fourth, were rural. Although rural areas account for roughly 60 percent of the nation's medically underserved population, they receive less than 25 percent of the available funding.

Under the community health center program, HEW currently spends more than $7.50 for every medically underserved urban resident, but only about $1 for every rural person residing in a medically underserved area. Even when the supplemental projects funded under the rural health initiative and HURA grants are added, the per capita expenditure in rural areas rises to only about $2.25.

In an attempt to rectify the imbalance, HEW recently established the rural health initiative program. During fiscal year 1977, more than 260 rural health projects were funded under the RHI program. However, it is to be kept in mind that these 260 rural health projects operated on a total budget of less than $23 million, while the 160 or so predominately urban community health centers received approximately $185 million.

Finally, I would like to make three specific recommendations and additions to the suggestions covered earlier.

(1) To assure a more equitable allocation of existing Federal resources among medically underserved areas, the Secretary of HEW should be required to set aside no less than 40 percent of all funds appropriated for community health center programs for the development and operation of health centers in rural areas.

(2) In view of the special health needs of migrant and seasonal workers, and the limited access many farm workers have to existing community health services, authorization and funding for migrant health programs should continue to be separate from the section 330 programs.

(3) In view of the importance of the community health center program and the limited hearings surrounding its extension, I would urge that additional time be scheduled for other public witnesses.

I respectfully request, Senator Javits, that a statement that I made this fall to the National Rural Health Council, as well as three reports on rural health that have been prepared by Rural America, be appended to my statement and included in the record.

Senator JAVITS. Without objection, it will be done, Dr. Kerr. And may I say to you that I am very sympathetic to the problem of extending my concept to medically underserved rural areas. I am not sure that I want to go 40 percent; that is a pretty big slice when you consider that almost 75 percent of all our people live in urban surroundings. But, that apart, we will study that carefully and do what needs to be done. I am certainly sympathetic to that.

Dr. KERR. I think that would be extremely helpful, Senator Javits.

Senator JAVITS. Now, gentlemen, Senator Hathaway has not returned. I am compelled to recess this hearing momentarily, as I must be elsewhere. But I am told by his staff that you may be excused, and we thank you very much, with the understanding that if there are any questions, they will be addressed to you in writing and your reply and the questions will be incorporated in the record in connection with your testimony, without objection.

[The prepared statement of Dr. Kerr and additional material subsequently supplied follows:]

STATEMENT OF LORIN E. KERR, M.D., M.S.P.H.

BEFORE THE

SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH

UNITED STATES SENATE

February 9, 1978

I am Dr. Lorin E. Kerr, Director of the Department of Occupational Health of the United Mine Workers of America. I am also a member of the Steering Committee of the Rural Health Council of RURAL AMERICA, a national association of individuals and organizations active in the health care field and particularly concerned with improving health conditions in our small towns and rural areas and access to health services by rural people. I appreciate the Subcommittee's invitation to appear here this morning, and to participate in the review of community Health programs provided under the Public Health Service Act. As requested, I will confine my remarks this morning to the proposed extension of the Community Health Centers program from the perspective of that program's effectiveness in addressing the health care needs of our rural citizens.

Proposed Extension

In preparing for these hearings, I have read with interest the proposed amendents to the Public Health Service Act contained in S. 2474, and recently introduced by Senators Kennedy, Schweiker and other members of this Subcommittee. I certainly concur with the sponsors of this legislation that

the community health and migrant health programs established under Sections 330 and 319 respectively of the Act have been effective in delivering needed health services to medically underserved people. For many people residing in both urban and rural "underserved" areas, publicly supported community health centers provide the only organized form of critically needed health services, and constitute an important part of the existing health delivery system.

I therefore fully support the proposal to expand the funding available to local communities through the Section 330 and 319 programs, and to expand the range of primary, supplemental, and environmental health services which can be furnished through migrant and community health centers and other community-based institutions. I am also particularly pleased to see the special concerns expressed by the sponsors of this legislation for the prevention of illness and disease, and the recognition of the importance of prevention as a part of a comprehensive community health services program. I feel strongly that any existing or new national health care system must emphasize priority for preventive community health efforts. It will certainly pay off in the long run, both in terms of a healthier nation and reduced costs, since preventive services are far less expensive and more cost effective than sickness services.

Community Health Centers and Rural People

While the Community Health Center program has demonstrated its effectiveness in meeting the acute health care needs of

people in many medically underserved areas, I believe that the experience to date demonstrates at least three major deficiencies. These can be summarized as follows: 1) limited funding; 2) restrictive funding requirements; and 3) a serious imbalance in the allocation of funds between urban and rural medically underserved areas. Since I believe that these issues have particularly serious consequences for people residing in small town and rural America, as well as important national implications, I would like to briefly discuss my concerns in these areas.

1. Available Resources: As has been pointed out by Senator Kennedy in introducing the Health Services Extension Act of 1978, the funds made available under the community and migrant health center programs have been wholly inadequate in view of the magnitude and scope of the health problems confronting our medically underserved population. As documented by the Administration itself, and confirmed by the Subcommittee, fewer than 10 percent of the medically underserved people in this nation are currently being reached through community and migrant centers. Even under the most generous proposals currently under consideration, including the Subcommittee bill S. 2474, it is estimated that community health services would be provided to only 12.5 percent of those individuals who are considered to be medically underserved. I strongly urge that we recognize the serious shortcomings of proceeding along the lines of what I have characterized as a "Medi-Gap" approach to meeting this society's health needs, and begin to move in the

direction of extending a full range of needed medical and health services to all individuals who are currently excluded from our health care system. The community health center program has and can make an important contribution toward meeting those needs, but substantially greater resources must be made available than those presently contemplated.

2. Restrictive Funding: As presently administered, the Community Health Center program has concentrated on the provision of a comprehensive range of primary health care services, and neglected important supplemental and environmental services. This has had a critical impact on the allocation of CHC funds and the ability of many rural communities to participate in the program or otherwise meet community health needs. In the first place, by mandating the provision of specified primary care services, which include such requirements as laboratory and radiologic services, transportation services, and preventive dental services, many smaller rural communities have been denied access to CHC funds because of their inability to provide all of the required services, or because the provision of the full range of such services would be prohibitively expensive or otherwise impractical. This "all or nothing" approach has seriously restricted the development of community health centers in rural areas.

Additionally, the exclusive focus on primary care services has worked to the real disadvantage of many rural communities whose serious health problems are closely linked to environmental factors such as inadequate domestic water and

sanitation facilities, poor housing, and malnutrition. Existing Administration policies affecting the funding of community health centers has denied many rural centers the resources necessary to furnish needed supplemental and environmental services, even though such services are clearly authorized by the Public Health Service Act, and were clearly intended by the Congress to become integral parts of community health efforts.

3. Funding Allocations: In recent weeks, increasing attention has been paid to the numbers of health centers which have been developed in urban and rural areas. I have seen, for example, reports which show that more than 65 percent of the community health centers financed under the Section 330 program operate in rural areas, leaving the clear impression that only limited attention has been paid to urban health needs. The truth, of course, is that the health needs of medically underserved people, both urban and rural, have been neglected, but that if we look at the allocation of funds rather than the number of projects, we find that rural areas have received only a small proportion of the Section 330 funds, although they contain a disproportionately large share of the medically underserved population.

Since its inception, the Community Health Center program has been largely geared to the health needs of people residing in our large urban centers, and has failed to provide anything close to equitable funding for rural centers. According to a recent report prepared by RURAL AMERICA, INC., a national nonprofit organization representing people in small towns and

rural areas, roughly 75 percent of the comprehensive community health centers, accounting for more than 80 percent of the funds, were located in the cities. For example, of the 158 centers funded in 1977, 122 operated in urban areas, and 36 centers, or less than one fourth, were rural.

Looked at from another perspective, although rural areas account for roughly 60 percent of the nation's medically underserved population, they receive less than 25 percent of the available funding. Under the Community Health Center program, HEW currently spends more than $7.50 for every medically underserved urban resident, but only about $1.00 for every rural person residing in a medically underserved area. Even when the supplemental projects funded under the Rural Health Initiative and HURA grants are added, the per capita expenditure in rural areas rises to only about $2.25.

In an attempt to rectify the imbalance, and in order to address special rural health problems, HEW recently established the Rural Health Initiative (RHI) program. During fiscal year 1977, more than 260 rural health projects were funded under the RHI program. However, it must be kept in mind that these 260 rural health projects operated on a total budget of less than 23 million dollars, while the 160 or so predominantly urban community health centers received approximately 185 million dollars.

Urban Health Initiative

Before closing, I wanted to comment briefly on the proposal submitted by Senator Javits to establish an urban health initiative as a part of S. 2474. The needs of medically

underserved urban areas which Senator Javits identifies are certainly critical. I am in full agreement with the intent of this proposed demonstration program which, as I understand it, would provide needed financial assistance to community hospitals for the conversion of excess space and facilities for the provision of needed primary care services.

I am troubled, however, that the proposed amendent would restrict such assistance to urban areas. Many of the health problems confronting urban underserved areas, including the effective utilization of existing local resources such as community hospitals, are equally great in rural areas. In rural America, we find a serious shortage of effective primary health care facilities and other resources, while a number of our smaller rural hospitals suffer from underutilized capacity and/or facilities. The potential for expanding primary care services in rural areas through the expanded utilization of existing community hospital facilities is significant, and I would urge this Subcommittee to give consideration to either 1) expanding the existing proposal to include eligible participants in both urban and rural areas, or 2) enacting a similar measure with comparable resources for assistance in medically underserved rural communities.

Conclusion

Finally, I would like to make a couple of specific recommendations in addition to the suggestions covered earlier.

1. To insure a more equitable allocation of existing federal resources among medically underserved areas, consideration should be given to requiring the Secretary of HEW to set aside no less than 40 percent of all funds appropriated for community health center programs for the development and operation of health centers in rural areas.

2. In view of the special health needs of migrant and seasonal farmworkers, and the limited access many farmworkers have to existing community health services, authorization and funding for migrant health programs should continue to be separate from the Section 330 programs. However, some mechanism should be established to assure that increases in the funding levels for the migrant programs keep pace with increased funding of community health centers under Section 330.

3. In view of the importance of the community health center program, and the limited hearings surrounding its extension, I would urge that additional time be scheduled for other public witness. This would provide the Subcommittee with an opportunity to undertake a more detailed review of the operations of these community health programs, and to hear from additional witnesses before a five year extension is adopted.

I have appreciated the opportunity to appear before you today, and hope that my testimony will be useful as you consider the extension of these programs.

THE ROAD WE HAVE COME: RURAL HEALTH NEEDS AND NON-RESPONSE *

by Lorin E. Kerr, M.D., M.S.P.H. **

Fiorella H. LaGuardia in 1944 stated with his inimitable vigor "When knowledge is not applied, it's wicked." In the same presentation at the Annual Meeting of the American Public Health Association in New York, Mayor LaGuardia went on to say "People have a right to medical care."

During the same meeting there was discussion of the problem of medical service for migrant workers and the excellent way in which it had been handled by the Farm Security and War Food Administrations. The APHA also adopted as its official policy a landmark report on Medical Care in a National Health Program.

This action put APHA squarely on record in favor of a national program which would make available for all people of the United States complete and adequate medical care of all essential types. It made it clear that such an end can be attained only by a decentralized but federally aided program; that it must be supported by compulsory insurance plus taxation or by taxation alone; and that it should be administered by a single public health agency at the federal, state and local levels.

This action was built upon the long and often isolated struggles to solve the onerous problem of paying doctor and hospital bills. Many of these involved rural groups banding together in health co-operatives such as the one formed it Elk City, Oklahoma in 1929. While health co-ops were

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* Presented at National Rural Health Conference held in conjunction with the Third National Conference on Rural America, Shoreham-Americana Hotel, Washington, D.C., December 5, 1977.

** Director, Department of Occupational Health, United Mine Workers of America.

given impetus by some urban workers they became the mainstay of the Farm Security Administration in working with low income farm families throughout the nation. Eventually there was an amalgam of the FSA program with the federal effort to overcome the unhealthy plight of migratory farm workers, particularly during World War II.

What has happened in the ensuing years? We have studied, reported, recorded and proved beyond a doubt--in fact the documentation is truly mountainous--that very little has changed. The litany of death and disability is essentially the same. The health facilities are in short supply and the same is true of all types of health personnel. The costs are astronomical and there is no indication that they will lessen or level off at any point in the foreseeable future.

Two years ago at the First National Conference on Rural America it was the considered opinion of the 1500 attendees that "Nowhere in the United States is the need for an improved health system more pressing and nowhere is it less adequate than in rural America." It was agreed the situation is getting worse, not better, despite the cheerful reports of the American Medical Association and some government officials. In the last 30 years the net efforts of tardy and miserly government efforts have not improved conditions so much as they have just barely prevented them from becoming scandalous.

An impressive array of health experts at the 1975 Conference delineated one after another the nation's rural health problems. Today, conditions are still the same. For example, infant mortality rates in rural medically underserved areas are double and triple the national norm, ranging in some cases up to 35 and 40 deaths per thousand live births. Twenty percent of all women of child-bearing age are rural, but they account for fifty percent of all maternal deaths. The message of these figures on infant and maternal mortality is quite clear--rural America offers a more hazardous environment than urban America.

Rural residents have a higher incidence of chronic conditions including digestive, respiratory and circulatory health problems. They have 22 percent more ulcers, 26 percent more cases of hypertension, and 29 percent more strokes than city residents.

Work related death and disability in rural communities have long constituted a major health problem which has only recently begun to attract serious national attention. Statistics for several decades have shown that traditional rural occupations such as mining, lumbering and agriculture are among the most dangerous to working people. Although our system of collecting information concerning all work related injuries is inadequate, it is particularly true for farm accidents and the effects of pesticides on humans. The mortality rate for rural workers is almost double that of their urban counterparts. Overall, our national record is extremely poor compared to other industrialized nations of the world.

In other areas of prevention 30,000 communities lack a centralized sanitary water system and this does not include isolated populations; sewer facilities are a serious problem for millions. In West Virginia, 60 percent of all homes have dangerous sewer systems. Sixty percent or less of rural children are immunized against communicable diseases.

One of the most serious health problems confronting the rural poor is under-nutrition and hunger. It is estimated that less than one-half of the 26 million Americans who cannot afford an adequate diet are receiving assistance through Federal food programs. A majority of these Americans live in rural America.

Briefly, this is the status of health in rural America. In this century we have managed to reverse the traditional relationship between urban and rural areas as far as the public's health is concerned. Today, on the basis of most indicators rural America is far less healthy than the dominant more urbanized part of society.

Most of us know that the distribution of health resources and personnel in rural America is as bad (and in some cases worse) as the distribution of other vital resources. The quickest way to learn what is wrong with our health system in general is to observe its particular malfunction in rural areas. At the heart of the crisis lies the gross mal-distribution of physicians and other health personnel. Overall the United States averages one doctor for every 665 persons. In urban communities the ratio is one doctor for every 500 persons, whereas in rural America for every 2400 residents there is only one physician. Looked at another way, although roughly a third of our national population resides in rural areas, they are served by only 12 percent of the nation's doctors, and just 18 percent of the nurses. The shortage means hardships for doctors, as well as patients, for rural physicians must work longer hours and see more patients.

Experience indicates that decent medical care can be provided with one doctor per thousand people. There is obviously a shortage of doctors and other health personnel, and those we have are distributed without much regard to need. But this is not a new problem.

Fifty years ago C.-E.A. Winslow, a widely acknowledged health expert, stated that state after state was complaining "of a grave lack of medical service of any kind in rural districts." He also noted that there was no attempt to

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meet this need with community grants to physicians who will consent to practice in such regions. Winslow was of the opinion that money alone was not the answer. The solution required good laboratory and hospital facilities and the ready availability of consultation with other well trained physicians.

Nearly three generations later state after state is still complaining--but more loudly because the situation has worsened. Today, it is estimated that to remedy the doctor deficit in rural areas would require over 100 percent of the U.S. and foreign medical school graduates for a full year--almost 20,000--not counting deaths and retirement.

The real remedy involves much more than locating 20,000 physicians--even if it could be accomplished--in doctor-less rural communities. These problems are manisfestations of sorely needed changes in our entire national delivery system which must be effected in the immediate future. More than 60 years ago Congress first held hearings on national health insurance. It was nearly 25 years later before the next Congressional hearings occurred. Since 1943 numerous proposals have been introduced but none achieved passage until Medicare and Medicaid were enacted in 1966. Today, there is, as you know, a wide variety of measures again before Congress which bear the label of national health insurance. The major proposal supported by organized labor and many other groups is the Kennedy-Corman Health Security Bill. This bill has been improved by two sets of earlier hearings. While it will assure the payment of doctor and hospital bills it does not resolve the basic problems which are still the prevention of disease, reorganization of delivery of services and financing. The absence of adequate cost controls such as continuance of the

fee-for-service method of paying doctors will undoubtedly permit the cost of medical care to rise from its current level of nearly 9 percent of the Gross National Product to somewhere around 12 to 15 percent in a very short time.

On October 18, 1976, in a historic statement four former presidents of the American Public Health Association declared their conviction that only a national health service act rather than national health insurance could solve America's health problems. They stated:

> "We are fearful that a national health insurance measure will be enacted into law that will repeat the serious mistakes of Medicare and Medicaid, and that will fail to address the really critical issues confronting this nation with respect to health care for the people. All of the many proposals introduced in Congress that are described as national health insurance bills are essentially financial mechanisms for providing guaranteed payments to the providers of health care services. They contain virtually no provisions for the reform or alteration of the American health care system. It has become more and more apparent, not only to health professionals and scholars but to much of the general public, that there are fundamental flaws in our system of providing health services which must not be incorporated into a new health system."

They then proceeded to identify the five major problems as follow:

1. Inflation of health costs is literally out of control.
2. Shortages of health workers are aggravated by giant increases in the costs of training.
3. The nearly complete exclusion of the consuming public from the decision making process of health policies would never be acceptable in any other sphere of American life.
4. The special needs of major segments of the American public are largely neglected. These include people in small towns and rural areas, ethnic and minority groups and many others.
5. Episodic medical care for sickness and disease is the primary characteristic of our health system.

The former presidents ended their statement as follows:

"We therefore call upon Congress to enact legislation to create a national health service which would be financed through progressive taxation, provide comprehensive health care with an emphasis on prevention and positive health promotion to all persons in the United States without charge and without any form of discrimination, to be controlled by the public in local communities with safeguards over quality and efficiency of health services delivery and expense, and with remuneration of providers based not on fee-for-services but on adequate salaries, as in all other public services."

Two days later APHA at its annual meeting called for a community-based national health service program embodying the recommendations of the four former presidents.

Congressman Ronald V. Dellums on May 4, 1977 introduced the National Health Service Act H.R. 6894. The bill is now being revised and will be re-introduced when Congress reconvenes after the first of the year. The major provisions of the bill assure that all residents of the United States will be included without exception; all health services for prevention, diagnosis, treatment and rehabilitation will be included and there will be no charges; and care will be provided primarily in publicly owned community health centers equipped with modern diagnostic and treatment facilities.

Special efforts will be made to close the gap between urban and rural areas by giving priority to the construction and staffing of health centers in the small towns serving rural communities. Improved transportation and communication facilities will be developed to make the services of these health centers easily accessible.

Where the problem is beyond the capacity of the community health center staff, the individual will be referred to a hospital or specialized center and if necessary, to the staff of the nearest University Medical Center. Should they be unable to handle the problem the individual will be sent with all transportation costs paid, to the national center that is equipped to handle the condition. These arrangements assure that there will be a two way flow of people and doctors between the community health centers and the national speciality centers, such as the National Institutes of Health here in close-by Bethesda. For the first time rural America can be assured of the ready availability and accessibility of quality medical care because physicians and other health workers will work together in group and team medicine, and will be stimulated by their colleagues to keep up to date.

The Dellums Health Service Act states that all health personnel will be salaried. Fee-for-service practice will be eliminated in the national health service. For those doctors who wish to remain in private practice there undoubtedly will be a small part of the population willing to pay their fees.

Training for the health professions will be tuition-free and graduates will serve for several years in underserved rural areas. Living allowances and free child care services, as needed, will remove major barriers to training. Admission policies for medical schools will favor not only those previously underrepresented--minorities, women, rural and working class students--but will draw a considerable portion of the student body from health workers, such as, nurses and technicians who already have demonstrated their commitment to improving the health of people.

The basic unit of the national health service will be the community served by a single health center, with a population varying considerably according to circumstances but usually of 25,000 to 50,000.

The administration will be at each level--federal, state, local--by a Department of Health. Each Department will be responsible to a governing board of which two-thirds of the membership will truly represent the people being served and one-third of the health workers providing the service. All health centers, hospitals and other health facilities will likewise be governed by these citizen dominated boards.

The keystone of the national health service will be the promotion of health and prevention of disease. At every level there will be strong divisions of disease prevention in the health departments which will take all available measures for the prevention and control of infectious, non-infectious, occupational and environmental diseases. Priority in research will be given to prevention.

The national health service will be consumer-oriented rather than provider-oriented. Health workers will be expected to have the welfare of the people they serve as their primary aims. In fact a portion of the health service bill will be devoted to the provisions necessary to assure the observance of these health rights.

The exact methods of financing the national health service are still to be worked out. They will, however, use the principle of progressive taxation, that is everyone's contribution will be based on ability to pay. This is very different from the regressive taxation of the social security system. The social security ceiling on the payroll tax means that workers and rural people with low incomes will pay a higher proportion of their income for national health insurance than do highly paid executives.

The nearly 9 percent of the Gross National Product (GNP) which we now spend for health services in the U.S. is too much for what we get. Much of it goes for unnecessary operations, unnecessarily high incomes of private practitioners and unnecessary waste and duplication. For 8 percent of the GNP, which is the limit on expenditures set by the Dellums National Health Service Act, a national service will assure the provision of a high quality of general services. In addition, it will also assure the provision of all the services badly neglected at the present time, such as, dental care, mental health and services for the chronically ill and aged.

A half century ago Winslow proposed that essentially the same program we are discussing today would solve the health problems he was observing in 1926. He anticipated criticism of the projects for organizing the medical service he outlined. Some he felt would be sound and significant, others merely superficial and frivolous. Then he added "The habit of condemning any

attempt at intelligent community action by labelling it as "socialistic" and "bureaucratic" is for example, unworthy of serious minded men. Some things are better done by the individual, some better by the state; and catchwords will not help us to determine to which class a given activity belongs."

While it is likely the same criticisms will be leveled at the Dellums Bill, a national health service is the only logical and rational way to solve our country's health problems. Medicare has already taught us that national health insurance, with all the good will in the world, cannot do it.

To help us move forward a little faster in resolving the ill health of rural America, I propose the formation of a national rural health organization. There is a need to assist rural people in their efforts to secure adequate representation on all health policy boards.

Of immediate urgency is the designation of rural consumer representation on the boards of the Health Systems Agencies (HSA's). The National Health Planning and Resources Act of 1974 allows consumer organizations to concentrate on one agency in each community. The law requires that the members and the executive committee of the local Health Systems Agency must be made up of "a majority--who are consumers of health care and who are not (nor within the 12 months preceding appointment have been) providers of health care and who are broadly representative of the social, economic, linguistic and racial populations, geographic areas of the health service area and major purchasers of health care."

This provision is the heart and centerpiece of the health-care planning legislation that numerous consumer groups and organized labor have been fighting for in the last 15 years. This is also what organized medicine has been

fighting against; this is what they have succeeded in sandbagging or watering down many times in order to preserve the status quo. This provision established the major battleground where a new people centered health-care system is going to take shape. It sets up a sensible and workable structure for community planning and community control that can serve as the model and nucleus of local administration for the health-care legislation Congress enacts.

The law is not perfect--it needs strengthening. But there is nothing more important than for consumer organizations to measure up to the opportunity and responsibility they have fought for so hard and so long. They must see to it that the consumer seats on the local Health Systems Agency and the state Health Planning and Development Agencies are filled by genuine consumers who know how to represent their fellow consumers.

A national rural health organization is needed to help bring together in a united front the diverse groups identified with and working for the development of health service programs meeting the needs of rural consumers.

A national rural health organization should also establish a center for the continuous exchange of relevant research, experience and opinion in the field of rural health. A national policy for improving the health of rural America should be developed by such a group. Other concerns would be the presentation of appropriate testimony at federal and state hearings on rural health legislation, assistance in the development of demonstration rural health projects and assistance in selecting, financing and training rural health personnel.

The beginnings of such a national organization identified as the American Rural Health Association have occurred in Alabama and will be reported

at this meeting by Stephen N. Barton, M.D. The American Public Health Association at its recent annual meeting here in Washington passed a policy statement calling for the formation by APHA of a National Rural Health Coalition. The statement also called for the establishment of a National Center for Rural Health. It is interesting to note that this is the first time the 105-year old APHA has made such a proposal.

I would strongly urge that we here acknowledge these other actions by forming a national rural health organization closely associated with Rural America.

The immediate task of this organization will be to seek the adoption and implementation of the policy statement and resolutions which emerge from this National Rural Health Conference.

To avoid jurisdictional disputes, I would further suggest that Dr. Barton and APHA be notified of our action and close working relationships be implemented.

In conclusion, I want to return to prevention because it is the crux of the action needed to reorganize the nation's health care delivery system. It has never come of age because medical care is usually limited to those services for which payment is made on the archaic fee-for-service basis. This method of paying doctor bills is well suited for episodic services, like the repair of a faulty television set. But only when this piece work system of paying doctor bills is changed can the full force of preventive medicine become effective. A new national health care system must emphasize priority for preventive community health efforts. It would certainly pay off in the long run, both in terms of a healthier nation and reduced costs, since preventive services are far less expensive and more cost effective than sickness services.

We must implement the philosophy of prevention which is best expressed by Milton J. Rosenau, M.D., an acclaimed public health leader who said in 1913,

> "Preventive medicine dreams of a time when there shall be enough for all, and every man shall bear his share of labor in accordance with his ability, and every man shall possess sufficient for the needs of his body and the demands of health. These things he shall have as a matter of justice and not of charity. Preventive medicine dreams of a time when there shall be no unnecessary suffering and no premature deaths; when the welfare of the people shall be our highest concern; when humanity and mercy shall replace greed and selfishness; and it dreams that all these things will be accomplished through the wisdom of man. Preventive medicine dreams of these things, not with the hope that we, individually, may participate in them, but with the joy that we may aid in their coming to those who will live after us. When young men have vision the dreams of old men will come true."

FEDERAL RESOURCES
& RURAL HEALTH

COMMUNITY HEALTH CENTERS

(RURAL HEALTH REPORT #2)

Rural America
1346 Connecticut Avenue NW Washington DC 20036

AUGUST, 1977

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This series of rural health reports was prepared by the staff of RURAL AMERICA. The project was made possible through the assistance of the Ford Foundation, but the Foundation should in no way be held responsible for the views expressed in these publications.

RURAL AMERICA is a nonprofit membership organization established to serve as a strong national voice on behalf of people in small towns and rural areas. Our main goal is to assure rural people equity in the formulation and implementation of public policies and programs. To meet these objectives, RURAL AMERICA carries out an active program of action-oriented research, technical assistance and training, legislative information, public education and advocacy.

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Community Health Center Program

History and Program Development

The Community Health Center (CHC) program is an outgrowth of earlier efforts by the Office of Economic Opportunity to help meet the primary care needs of low income people. Under the OEO initiated program, Federal funds were utilized to establish neighborhood clinics and other types of health centers in both urban and rural areas.

During 1972 and 1973, various aspects of the program were transferred from OEO to HEW. Under Section 330 of the Special Health Revenue Sharing Act of 1975,(PL 94-63), the funding operation of neighborhood health centers and other types of comprehensive health centers were consolidated into the Community Health Center program. This program is administered by the HEW Bureau of Community Health Services (BCHS). Under the program, grants are available to public and nonprofit private organizations providing a broad range of health services to the community. Grants cover the operating costs of the clinic and the provision of health services. Funds for the acquisition or construction of medical facilities are not available through the CHC program.

Community Health Centers emphasize comprehensive health care, although the number and scope of services provided varies somewhat

depending upon the health center. PL 94-63 requires Community Health Centers to provide primary health services such as services of physicians and, where feasible, physician extenders; diagnostic laboratory and X-ray services; preventive health and dental services;and transportation and emergency medical services. In addition to these required services, many health centers also provide or arrange for the provision of supplemental health services such as hospital services, home health services, extended care facility services, mental health services, dental services, vision services, allied health services, pharmaceutical services, public health services, health education services, and others.

During the past few years a concerted effort has been made by the Bureau of Community Health Services to improve the management capabilities of community health centers. Ambulatory health care information systems and uniform cost accounting systems have been developed. Vigorous efforts are being made to increase third-party reimbursements. A list of funding criteria dealing with management, policy, financial and quality-of-care considerations has been developed and is used by HEW in making funding decisions.

Program Expenditures

Funds to Rural CHCs

The Table on the following page indicates that the major portion of CHC funds has gone to comprehensive health centers in urban

areas. In FY 1973, approximately $191 million went into a total of 157 CHCs. Only $36.7 million, or 19.2 percent of these funds went into rural health centers. In FY 1974, only $42.6 million, or 21.4 percent of CHC funds went into rural projects. For FY 1977, it is projected that $36.9 million, or only about 17 percent of the total CHC grant funds will go to ongoing rural comprehensive health centers.[1/] Viewed from another perspective, there are currently 164 community health centers. One hundred and fifteen, or seventy percent are urban, and 49 centers, or less than one-third are rural.[2/] Thus, since its inception, the Community Health Center program has been predominantly urban.

In an attempt to rectify the imbalance between CHC funds going into urban and rural health centers, the Bureau of Community Health Services created the Rural Health Initiative program in 1975. The Bureau redirected $7.3 million of the Community Health Center funds into the RHI in its first year.[3/] The RHI program provides operating funds for rural health projects. It does not provide funds for rural comprehensive health centers. (See following chapter for fuller discussion of RHI program.)

1/ Telephone interviews with Community Health Center program staff member, Washington, D.C., March 23, 1977 and April 29, 1977.

2/ Ibid., 7 March 1977.

3/ Ibid.

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BREAKDOWN OF CHC FUNDING

FISCAL YEAR	TOTAL CHC GRANT FUNDS (Millions)	URBAN CHC's	RURAL CHC's	RHI PROJECTS	PERCENT OF FUNDS RURAL
1973	$ 191.0	154.3	36.7	-	19.2%
1974	199.4	156.8	42.6	-	21.4
1975	193.1	154.2	31.6	7.3	20.1
1976	191.7	144.8	29.7	17.2	24.5
1977*	215.1	147.5	36.9	24.7	28.6
TOTAL	$ 990.3	757.6	177.5	49.2	22.9

Source: HEW/Community Health Center program staff in Washington, D.C.

* This year's figures are projections, and include approximately $6 million for a newly created Urban Health Initiative.

CHC Funding Level

The funding level for ongoing community health centers has remained relatively constant over the past few years. As previously noted, approximately $191 million went into 157 projects in FY 1973. Grant funds for the Community Health Center program for FY 1977 will total approximately $215.1 million.[4/] Of this amount, it is projected that $24.7 million will go into the RHI program, and about $6 million will go into a newly created urban health initiative.[5/] The remaining $184.4 million is grant funds for the 164 ongoing community health centers. Therefore, despite an apparent increase in funding for FY 1977, about $30 million will be put into other BCHS efforts, leaving the current traditional community health centers at a funding level actually below the FY 1973 level.

Commentary

The Community Health Center program has greatly increased the poor's access to health services in many underserved areas. Further, the provision of comprehensive health care with an emphasis on preventive care has been an extremely beneficial aspect of the program. Studies have shown that many of these projects have succeeded in reducing infant mortality rates, serious illness, and serious hospitalization.[6/] Unfortunately, limited funding over the past several years has prevented this program from expanding to addi-

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4/ Ib.d

5/ Ibid.

6/ Southern Rural Health Conference, Report and Recommendations. Washington, D.C.: National Rural Center, 1976, Page 27.

tional needy communities. Moreover, as previously indicated, the urban bias of the CHC program has meant that currently only 49 CHCs, or 30 percent, are rural.

Limited funding has also caused financial difficulties for some of the ongoing community health centers. Clinic administrators and planners contacted during the course of this study explained that the requirement that comprehensive health care be provided, including, in many instances, financial responsibility for hospital and other extended care, is extremely costly to the health centers. The centers also provide a number of other essential services such as transportation, medical outreach, and health education. The cost of these services is not reimbursable, however, and consequently must be absorbed by the clinics. This particularly affects rural centers, since a large segment of rural people do not have private health insurance plans. Further, the two major public financing programs for health care, Medicare and Medicaid, are strongly biased against rural areas. As an overall result, budget restrictions have caused many clinics to cut back on the range of their services in recent years, with preventive care and environmental health services often being the first ones eliminated.

A very serious problem for rural community health centers is Medicare's restrictions on the reimbursement of services rendered by nurse practitioners and other physician extenders. Under the

present law, the services of physician extenders are reimbursable under Medicare only if these services are provided under the direct personal supervision of a physician. Almost two-thirds of the rural community health centers have satellite clinics which use physician extenders, and ineligibility for reimbursement for these services greatly contributes to their financial difficulties.

Health centers which continue to provide a broad range of services to low-income populations will not be able to meet their costs through collections or third-party reimbursements for services. Congress is in the process of considering the funding level for fiscal year 1978. It is hoped that they will appropriate a significant increase in funds to allow existing centers to continue to provide comprehensive health care and to expand the program into additional needy communities.

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FEDERAL RESOURCES
& RURAL HEALTH

RHI & HURA PROJECTS

(RURAL HEALTH REPORT #3)

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Rural America
1346 Connecticut Avenue NW Washington DC 20036

AUGUST, 1977

RURAL HEALTH REPORTS

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9	Public Financing of Health Services: Medicare and Medicaid

This series of rural health reports was prepared by the staff of RURAL AMERICA. The project was made possible through the assistance of the Ford Foundation, but the Foundation should in no way be held responsible for the views expressed in these publications.

RURAL AMERICA is a nonprofit membership organization established to serve as a strong national voice on behalf of people in small towns and rural areas. Our main goal is to assure rural people equity in the formulation and implementation of public policies and programs. To meet these objectives, RURAL AMERICA carries out an active program of action-oriented research, technical assistance and training, legislative information, public education and advocacy.

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Rural Health Initiative

Goals and Specifications

To deal with the acute shortage of rural health services and the failure of the Community Health Center program to effectively address this need, in 1975 the Bureau of Community Health Services (BCHS) created the Rural Health Initiative (RHI). The Rural Health Initiative is an administrative effort combining existing health resources of HEW to provide grants and technical assistance to local nonprofit organizations and groups for the development of rural health care delivery systems. Under the program, grants are available to nonprofit groups to cover the operating costs of community health clinics, satellite clinics and other health projects in underserved rural areas. The program's grant funds come from the Public Health Service Act, Section 330, which is the Community Health Center Program, and Section 319, the Migrant Health Program.

Priority has been given to placing projects in those nonmetropolitan areas with the greatest need for health services. Some of the indicators of need considered in project selection are high proportion of migrant farmworkers, poor transportation, and low physician/patient ratios.

All rural health projects provide physicians' services, including preventive, diagnostic, and therapeutic treatment.

Projects also provide emergency medical services including transportation, laboratory and x-ray services and linkages for hospitalization. Nurse practitioners, physician assistants and other physician extenders are often employed at the projects.

Health Underserved Rural Areas Program

The Health Underserved Rural Areas (HURA) Program is a project grant program for rural health research and demonstration administered by BCHS as a key component of the Rural Health Initiative. The program is funded under Title XIX (Medicaid) of the Social Security Act. The purpose of the program is to develop projects to provide better health care to the Medicaid eligible population.

Program Expenditures and Growth

RHI/HURA grants up to $200,000 are available to cover the operating costs of rural health projects. Funding is available for a total of three years, with decreasing amounts for the second and third year. Projects are expected to become economically self-sufficient within three years.

The Rural Health Initiative program has grown significantly since its inception three years ago. In FY 1975, forty-seven RHI and nine HURA projects were funded for a total of $10.6 million. In 1976, $27.2 million was put into 138 RHI and 53 HURA projects. The FY 1977 budget is approximately $44.7 million, and it is estimated that by the end of this fiscal year a total of 353 projects

will have been funded under the program.[1/]

A limited number of planning and development grants of up to $25,000 have been made available recently to communities to aid them in assessing their health care needs and developing grant applications. Approximately 40 of these grants will be available in FY 1977, with the first awards scheduled to be made in May.[2/]

As a result of the grant support now provided to the 191 primary care projects supported through the RHI/HURA program, 459 rural counties will receive health services. Included are parts or all of 375 counties designated as critical health manpower shortage areas; and 180 counties having the highest infant mortality. In addition, six of the thirteen high migrant impact areas in non-SMSAs not previously served will now receive services through RHI projects.[3/]

1/ U. S. Department of Health, Education and Welfare, Public Health Service, "Background information on the Public Health Service Rural Health Initiative for Rural Health Policy Workshop, December 15, 1976," 1976, Page 3, (Xeroxed).

2/ Telephone interview with Rural Health Initiative program staff in Washington, D.C., March 22, 1977.

3/ U. S. Department of Health, Education and Welfare, Public Health Service, "Background Information," Pages 4-5.

Linkages

Whenever possible, RHI projects are linked to other Public Health Service programs. Thus far, approximately half of the projects have been staffed by the National Health Service Corps. According to HEW officials, referrals and consultation relationships with Community Mental Health Centers have been developed or are in the process of being developed in 82 projects. Linkages with alcoholism programs have been or are in the process of being developed in 51 projects. Additional linkages of BCHS administered programs, such as the Migrant Health and Appalachian Regional Programs, are continuing, and linkages with other programs are being initiated.[4/]

Commentary

The Rural Health Initiative represents a significant effort to deal with the crisis in rural health care. Many of the clinics established under the RHI program serve rural areas where primary health care has not previously been available. But a very large number of underserved rural areas have not been reached. These areas could benefit greatly from the continuation and expansion of this program.

Unfortunately, the RHI is currently in an extremely tenuous position, as it is only an administrative effort with no legislative

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4/ Ibid.

authorization. In addition, there are no administrative funds to support the development and expansion of the RHI, and there is very little money available for planning grants and technical assistance to needy communities. In an uncertain political environment, where efforts to meet urban needs have frequently taken precedence over rural needs, the RHI could easily come to an abrupt end.

Another problem is that the diversion of Community Health Center and Migrant Program funds for use in RHI projects has already provoked concern among affected groups. Spokesmen for migrant farmworker organizations have expressed strong reservations about the use of Migrant Health Program funds in health projects that are not primarily designed to meet the special needs of migrant and seasonal farmworkers. (Rural Health Report #7 "The Migrant Health Program," discusses this issue in greater detail.)

Still another issue which has caused considerable concern is the RHI program goal of economic self-sufficiency for its projects. Such independence may be possible in areas with high income or where many residents are covered by private health insurance or public financing programs, but extremely difficult in low-income areas where people cannot afford to pay for medical care. Since many rural people do not have their own health insurance or benefit from the Medicare and Medicaid programs, the lack of adequate reimbursement mechanisms has made self-sufficiency next to impossible for many RHI projects.

The HEW Bureau of Community Health Services recognizes the many obstacles to economic self-sufficiency for rural clinics. According to BCHS staff, the goal of self-sufficiency should not be interpreted as a strict requirement. They explain that an RHI project will continue to receive Federal grant support after the initial three-year period if it is evident that the clinic is using its funds efficiently to deliver quality health services and is making every effort to maximize third-party reimbursements.[5/] Outside of HEW, however, there is much speculation that continued grant support cannot be guaranteed in the absence of legislative authority.

In order to insure the continuation and strengthening of the RHI program, the following recommendations are suggested:

- The RHI Program should be legitimized and protected through Rural Health Initiative legislation.
- Separate funding should be sought for the program, with appropriation levels commensurate with the need, including adequate funds for planning grants and technical assistance.
- RHI legislation should specify that RHI/HURA projects that fail to achieve economic self-sufficiency after three years should continue to receive Federal support as long as they are meeting legitimate low income needs.

5/ Michael Samuels, Associate Director of BCHS, "Federal Initiatives in Support of Rural Health," a speech given on April 1, 1977 at the American Medical Association's 30th National Conference on Rural Health.

It appears that there already exists considerable Congressional support for the Rural Health Initiative. In addition, Administration officials have expressed interest in the RHI program. Proponents hope that the 95th Congress will initiate legislation to protect this program for rural Americans and that the new Administration will lend support to these efforts.

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Senator JAVITS. Now, there are two more witnesses, Mr. Outcalt and Dr. Aledort. Would you be good enough to stand by for about 5 minutes? I am sure Senator Hathaway will be right back. The hearing is recessed until 12 o'clock.

[Whereupon, a brief recess was taken.]

Senator HATHAWAY. Mr. Outcalt, why do you not go ahead? You are accompanied by Paul Wright, John Barrasso, and Rich Roberts.

STATEMENT OF DOUG OUTCALT, NATIONAL PRESIDENT, AMERICAN MEDICAL STUDENT ASSOCIATION, AND FOURTH-YEAR MEDICAL STUDENT, UNIVERSITY OF ARIZONA, ACCOMPANIED BY PAUL R. WRIGHT, EXECUTIVE DIRECTOR, AMERICAN MEDICAL STUDENT ASSOCIATION AND AMERICAN MEDICAL STUDENT ASSOCIATION FOUNDATION; JOHN BARRASSO, TRUSTEE-AT-LARGE, AND FOURTH-YEAR MEDICAL STUDENT, GEORGETOWN SCHOOL OF MEDICINE; AND RICH ROBERTS, NATIONAL HEALTH SERVICE CORPS SCHOLARSHIP STUDENT, AND SECOND-YEAR STUDENT, GEORGE WASHINGTON UNIVERSITY SCHOOL OF MEDICINE

Mr. OUTCALT. Mr. Chairman, we would like to express our appreciation for the opportunity to be here today. It is an honor on behalf of AMSA, and we thank you and your committee.

I will skip the second paragraph, as you have already named the people who are accompanying me, and just say that my name is Doug Outcalt and I am a fourth-year medical student at the University of Arizona, currently taking a year away from medical school serving as President of the American Medical Student Association.

AMSA is a totally independent, national organization with over 20,000 members at 128 allopathic and osteopathic medical schools. We have a long history of commitment to improving medical education, health care services, and health care delivery. Over the past 10 years, we have run a variety of field programs for health science students which have exposed more than 10,000 young health professionals to innovative health care delivery systems and challenging opportunities in underserved areas.

Many of these students have returned to these areas—in Appalachia, on American Indian reservations, in the inner city neighborhoods, and in small rural communities—to establish a permanent practice.

Our organization has a history of support for the National Health Service Corps which extends back to the original legislation. Many of our past members and officers have worked for the corps as practitioners and in administrative positions. We currently recruit young physicians for the National Health Service Corps, Indian Health Service, and Bureau of Medical Services through the AMSA Foundation's advocacy and recruitment program, which is supported by these three branches of the Public Health Service. We have, in the past, run student preceptorship programs for the National Health Service Corps.

AMSA remains very supportive of the corps and the National Health Service Corps scholarship program. We feel this has been, by far, the best attempt by the Government, or anyone else, to address the problem of physician maldistribution. We would like to commend those who administer the Corps at the national and local levels for their dedication and hard work. We are very committed in seeing the National Health Service Corps succeed in providing chronically underserved communities with a long term solution to their health care needs. It is with this outlook that we offer the following observations and suggestions.

At one time, young physicians in training viewed the Public Health Service scholarship program as a vehicle for accomplishing their goal of providing health care services in underserved areas. Today, there is an increasing tendency of physicians in training to view the program as a means of financing the ever spiraling costs of a medical education in exchange for a service obligation.

It is slowly ceasing to be an attractive option and becoming, instead, a last resort. This attitude is reflected by a decline last year in the number of scholarship applicants. Our perception is that the reasons for this trend are complex and include the following: (A) Lack of clear and regular communications from the Corps to scholarship recipients; (B) Lack of personal and professional growth opportunities, and guidance for seeking them out, for scholarship recipients related to their future service experience; (C) Lack of preparation for practice in underserved communities; (D) There is the uncertainty of eventual assignment as to which service, either the National Health Service Corps, Indian Health Service, or Bureau of Medical Services, an obligee will be placed in (E) The possibility of a $1,500 penalty for applying, being accepted, and then deciding not to participate in the program; (F) The discrepancy in incentive pay between obligated and volunteer Corps physicians; and (G) A general feeling of uncertainty about how young physicians will be treated by a Government program.

We feel that the scholarship program need not be viewed as a coercive system. It can be a positive personal and professional growth experience in which young physicians will want to participate. We suggest that once a medical student enters the scholarship program, the Corps should begin the process we refer to as acclimation—regular communications about the Corps; the types of placement mechanisms; available practice models and locations, and other general information, as well as growth experiences to prepare for serving.

Field experiences should be provided for all scholarship recipients at Corps sites, and training provided on vital nonclinical skills, working with health teams, analysis of community health problems, preventive medicine, patient education, grantsmanship, mobilizing resources at the Federal and State levels, working with community boards, and dealing with crisis situations.

Anyone not wanting to participate in these experiences should not be involved in the scholarship program. Those recipients who discover, through these experiences, that they are not suited for this type of program and practice challenge should be dropped, with no further expense to the Government. Scholarship support should only

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be for those individuals willing and inclined to meet the total nature of the commitment.

These nonclinical skills are essential for a successful practice in an underserved area, and are not currently being taught in medical schools or postgraduate training programs. The Corps should seize the opportunity to enhance its image by providing learning opportunities in these areas to medical students and other young physicians as potential Corps recruits.

At the very minimum, the Corps should provide professional guidance to scholarship recipients throughout their training. This counseling could include how best to schedule elective time and choose the most appropriate residency programs, so as to prepare oneself for rural or inner city practice. Not only would this approach insure the Corps of practitioners who are properly prepared to deal with a wide range of nonclinical problems which have a direct effect on the quality of care and desire to remain in a challenging practice setting, but it would also document the needed fact that the program believes in backing up and investing in its people.

Through our community technical assistance efforts, we have learned that there is also critical preparatory work which should be done with communities to prepare them for receiving Corps physicians. We have come to respect the community's role, as it is often the essential ingredient to a successful experience for the Corps and the young assignee.

It is imperative that skills and knowledge be invested in this group so that the practitioner and community components meld into an effective working force. Communities need to understand their responsibilities in creating an environment conducive to practitioner and health service development, and to have a feeling of moving toward self-sufficiency in the long term. To achieve this, it will require a new commitment by the Corps to analyze its field problems and to develop and maintain an effective field-support system for its practitioners, their families, and communities.

We urge that young physicians with service obligations be given as much choice as possible as to which location and service branch they will be practicing in. We believe that the steps taken this year by the Corps, such as the conference for scholarship recipients and their spouses, as conducted by the AMSA Foundation's advocacy program, should be continued. They were a needed, appreciated, and effective step, not only in placement, but in improved communication between the scholarship recipients and the Public Health Service.

We think that if given the opportunity to make an informed decision, young physicians will have a variety of preferences which will include both rural and urban areas, as well as Federal prisons, Public Health Service hospitals, and the Indian Health Service. An open system which emphasizes full participation will help sustain a high level of motivation within the Corps professional community.

We welcome the interest within the Corps in expanding into urban areas. The need is clear and critical. However, we would advise caution, and strongly recommend a balance in the program be maintained to accommodate both rural and urban needs and practitioner expectations.

Finally, we would also urge that any penalties associated with the application process for the scholarship program, along with any differences in incentive pay received by Corps physicians who are obligees and volunteers, be eliminated. A permanent solution needs to be found to the problems created by the new tax status of service-dependent scholarships effective 1980, so that scholarship recipients at high-tuition schools will not have to borrow money to continue on the scholarship program.

We would like to conclude by reiterating our strong support for the National Health Service Corps and the scholarship program. We offer these suggestions in the hope that the corps can be viewed by young physicians as an opportunity for personal and professional growth, and by communities as a long-term solution to their health care needs.

The corps has the opportunity to develop a truly innovative, model program for practitioners and communities to work together for their mutual benefit. AMSA offers its continued assistance in this effort. Thank you.

Senator HATHAWAY. Have you communicated these concerns to the corps?

Mr. OUTCALT. Yes; we are in close communication with the corps through the advocacy program, which I mentioned before, and have, on occasion, expressed these concerns; yes.

Senator HATHAWAY. What has been their response?

Mr. WRIGHT. The dialog between AMSA and the corps is very close, and the corps is making progress on the kinds of things indicated for which they are to be commended. But I think the legislative process needs to be more specific to make sure those kinds of needs are met, and not to just depend on the initiative of the administrators of the NHSC program.

Senator HATHAWAY. You think we ought to legislate these concerns?

Mr. WRIGHT. I think the legislation should be as specific as possible, leaving little doubt what the intent of Congress is in meeting these kinds of needs.

Senator HATHAWAY. Thank you very much for expressing these concerns, and we will do what we can to incorporate them into the pending amendments.

Mr. OUTCALT. Thank you.

[The joint prepared statement of Mr. Outcalt, Mr. Wright, Mr. Barraso, and Mr. Roberts follows:]

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STATEMENT OF

DOUG OUTCALT
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AND

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JOHN BARRASSO
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BEFORE THE

SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH
COMMITTEE ON HUMAN RESOURCES

UNITED STATES SENATE

THURSDAY, FEBRUARY 9, 1978

Mr. Chairman, we would like to express our appreciation for the opportunity to appear here today. It is an honor and on behalf of AMSA we thank you and your committee.

My name is Doug Outcalt and I am a fourth year medical student at the University of Arizona College of Medicine and I'm currently taking a year away from school to serve as President of the American Medical Student Association. Here with me are: John Barrasso, AMSA Senior Trustee-at-Large; Rich Roberts, AMSA Federal Legislative Affairs Coordinator and National Health Service Corps Scholarship recipient; and Paul Wright, Executive Director of the American Medical Student Association and the AMSA Foundation.

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AMSA remains very supportive of the Corps and the NHSC Scholarship Program. We feel this has been by far the best attempt by the government, or anyone else, to address the problem of physician maldistribution. We would like to commend those who administer the Corps at the national and local level for their dedication and hard work. We are very committed in seeing the National Health Service Corps succeed in providing chronically underserved communities with a long term solution to their health care needs. It is with this outlook that we offer the following observations and suggestions.

At one time, young physicians in training viewed the Public Health Service (or NHSC) scholarship program as a vehicle for accomplishing their goal of providing health care services in underserved areas. Today there is an increasing tendency for physicians in training to view the program as

a means of financing the ever spiraling costs of a medical education in exchange for a service obligation. It is slowly ceasing to be an attractive option and becoming instead a last resort. This attitude is reflected by a decline last year in the number of scholarship applicants. Our perception is that the reasons for this trend are complex and include the following:

A. lack of clear and regular communications from the Corps to scholarship recipients;

B. lack of personal and professional growth opportunities, and guidance for seeking them out, for scholarship recipients related to their future service experience;

C. lack of preparation for practice in an underserved community;

D. there is the uncertainty of eventual assignment as to which service (NHSC, IHS, BMS) an obligee will be placed in;

E. the possibility of a $1,500 penalty for applying, being accepted and then deciding not to participate in the program;

F. The discrepancy in incentive pay between obligated and volunteer Corps physicians;

G. A general feeling of uncertainty about how young physicians will be treated by a government program.

We feel that the scholarship program need not be viewed as a coercive system. It can be a positive, personal and professional growth experience in which young physicians will want to participate.

We suggest that once a medical student enters the scholarship program the Corps should begin the process we refer to as acclimation - regular communications about the Corps, the types of placement mechanisms, available practice models and locations and other general information, as well as growth experiences to prepare for serving.

Field experiences should be provided for all scholarship recipients at Corps sites and training provided on vital non-clinical skills such as setting up a rural or inner city practice, working with health teams, analysis of community health problems, preventive medicine, patient education, grantsmanship, mobilizing resources at the federal and state levels, working with community boards and dealing with crisis situations. Anyone not wanting to participate in these experiences should not be involved in the scholarship program. Inasmuch, those recipients who discover through these experiences that they are not suited for this type of program and practice challenge should be dropped with no further expense to the government. Scholarship support should only be for those individuals willing and inclined to meet the total nature of the commitment.

These non-clinical skills are essential for a successful practice in an underserved area and are not currently being taught in medical schools or postgraduate training programs. The Corps should seize the opportunity to enhance its image by providing learning opportunities in these areas to medical students and other young physicians as potential Corps recruits.

At the very minimum, the Corps should provide professional guidance to scholarship recipients throughout their training. This counseling could include how best to schedule elective time and choose the most appropriate residency program so as to prepare oneself for rural or inner city practice. Not only would this approach insure the Corps of practitioners who are properly prepared to deal with a wide range of non-clinical problems which have a direct effect on the quality of care and desire to remain in a challenging practice setting, but it would also document the needed fact that the program believes in backing up and investing in its people.

Through our Community Technical Assistance efforts we have learned that there is also critical preparatory work which should be done with communities to prepare them to receive Corps physicians. We have come to respect the community's role as it is often the essential ingredient to a successful experience for the Corps and the young assignee. It is imperative that skills and knowledge be invested in this group so that the practitioner and community components meld into an effective working force. Communities need to understand their responsibility of creating an environment conducive to practitioner and health services development and to have a feeling of moving toward self sufficiency in the long term. To achieve this, it will require a new commitment by the Corps to analyze its field problems and to develop and maintain an effective field support system for its practitioners, their families and communities.

We urge that young physicians with service obligations be given as much choice as possible as to which location and service branch they will be practicing in. We believe that the steps taken this year by the Corps such as the conference for scholarship recipients and their spouses as conducted by the AMSA Foundation's Advocacy Program should be continued. They were a needed, appreciated, and effective step not only in placement but in improved communication between the scholarship recipients and the Public Health Service. We think that if given the opportunity to make an informed decision, young physicians will have a variety of preferences which will include both rural and urban areas as well as federal prisons, Public Health Service Hospitals, and the Indian Health Service. An open system which emphasizes full participation will help sustain a high level of motivation within the Corps professional community.

We welcome the interest within the Corps in expanding into urban areas. The need is clear and critical. However, we would advise caution and strongly recommend a balance in the program be maintained to accommodate both rural and urban needs and practitioner expectations.

Finally, we would also urge that any penalties associated with the application process for the scholarship program, along with any differences in incentive pay received by Corps physicians who are obligees and volunteers, be eliminated. A permanent solution needs to be found to the problems created by the new tax status of service-dependent scholarships effective

1980 so that scholarship recipients at high tuition schools won't have to borrow money to continue on the program.

We would like to conclude by reiterating our strong support for the National Health Service Corps and the scholarship program. We offer these suggestions in the hope that the Corps can be viewed by young physicians as an opportunity for personal and professional growth and by communities as a long-term solution to their health care needs. The Corps has the opportunity to develop a truly innovative, model program for practitioners and communities to work together for their mutual benefit. AMSA offers its continued assistance in this effort.

Thank you.

Senator HATHAWAY. Dr. Aledort?

STATEMENT OF LOUIS ALEDORT, M.D., MEDICAL DIRECTOR, NATIONAL HEMOPHILIA FOUNDATION, AND VICE CHAIRMAN OF THE DEPARTMENT OF MEDICINE, MOUNT SINAI HOSPITAL, NEW YORK, N.Y.

Dr. ALEDORT. Senator Hathaway, thank you very much for giving me the opportunity to address a specific element in the Health Services Extension Act of 1978, and that is to deal with sections 1131 (e) and (f), the Blood Separation Center program and the Hemophilia Diagnostic and Comprehensive Treatment Center support program.

I would like to address the Separation Center first by telling you what has been accomplished and what has been done with some of the appropriated money over the past year and a quarter. There were two aspects of the work that was done. One was to understand and define the relative supply needs and demands for factor 8 and factor 9 for hemophilia patients.

I have submitted the Booz, Allen & Hamilton report that has evolved out of that study. In essense, until 1975, the needs of factors 8 and 9 were not met. However, since 1975, they have been met by the commercial industry that is supplying material. However, we are facing several unsolved problems. One has been a trend to prophylactic use to make patient recipients of this treatment even more effective, and we have seen a growth on use of product from an average of 10,000 units per patient in 1970 to approximately 50,000 per year at this present time, and the patients are living longer.

In addition, we have inflationary costs, and several other areas related to the production of this material. One is that we have some knowledge as to how to break up blood into its multiple components, so that hemophiliacs, leukemics, cancer patients can get those pieces. However, we have not yet seen a significant enough move in that direction throughout the country.

Technology at present is very poor, and the yield from original source plasma to final product is a major problem. In addition, the major resources for factors 8 and 9 are within the United States, and there is increasing exportation of this material to the rest of the world.

In addition, we have a pilot project that has been supported by some of these funds to see whether a voluntary program can use component therapy in a more effective fashion to make this material available. At present, we cannot meet the eight and nine demands by bleeding people only with whole blood, and therefore have resorted to plasmapheresis, and there is very little evidence in this country that we can move that to a voluntary program.

Therefore, we really do need, and support wholeheartedly, the recommendation to continue this separation center for at least 3 more years, so that funds could be used to encourage the utilization of component therapy, and to increase the yield of this material from source plasma, so that we are not caught in a major commercial crunch where plasmapheresis is the only source of material.

In terms of the Hemophilia Diagnostic and Comprehensive Treatment Center, the first year that the funds were made available, 17 centers were funded throughout the United States, with few of them going to areas without previous experience. However, in the second year, which started October 1, 21 centers have been funded, and now there are several areas where neophytes in the treatment programs have actually received funds and are cooperating with those established programs to make available this comprehensive care.

Some of the major accomplishments that we can actually measure, and which have been done on five of the centers being evaluated since October, have shown that in the five centers, there has been an increased patient identification within the region that they cover, by 25 percent. The comprehensive care which only got to 10 percent of those patients already identified, was now increased to 25 percent. The utilization of home care—that is, the ability to get the patient out of the hospital, self-treating, and back at work and school—has increased by 25 percent.

In addition, a marked increase in services giving comprehensive care has evolved. We have been able to get more patients detected for the carrier State; we have been able to provide social and behavioral science, and genetic counseling services through these centers to patients. In adddition, these programs have been very much aware of the problem of reduplication of services within the region, and have begun an outreach program to minimize it.

There are some very good examples. In New York City, the Mount Sinai Hospital and the New York Hospital have taken over a large region and do not duplicate any service, using each other's support system to manage almost 500 or 600 students. The same is true now for Chapel Hill and Bowman Gray, and the Mayo Clinic and the University of Minnesota.

The other thing that is important is that of the five regional centers that exist in the total Northeast, they now cover an outreach into 9 states, making it unnecessary to provide new centers within that region, and actually educate themselves on treatment programs.

We have been able to effectively form networks in the areas of catchment and association, and have begun uniform data collection throughout the country. In addition, since the major problem in this disease is the cost, we have been able to work very closely with third-party payment programs within some of the areas.

I would just like to present, briefly, two pieces of data that might be interesting. In Kentucky, four cases were studied specificially as to cost effectiveness, and these patients used a total of $19,500 for 227 hospital visits. And when they were converted into a home care program, the costs dropped to $10,817—a savings of $8,700 for four cases in a given year.

In the Seattle region, we have increased identification of patients from 128 to 241; and by having 50 percent of the patients converted in that region to a home care program, we have saved $55,000 in ambulatory visit costs by this change.

The Foundation has worked closely with the Health Services Administration, both locally, at the State level, and at the Federal level, to coordinate the efforts of these funds. This month, all of the centers

will meet to deal with the problems of data collection, patient identification, and educational programs.

We feel we continue to remain an ideal example of comprehensive care to a chronic, lifelong illness that can be reverted by plasma infusions. However, we feel that we still feel that we have a lot to be done. At the same time that we are utilizing Federal funds, we are actively working on local programs to support those existing programs and those that will be developed, so that within a period of, hopefully, 10 years, we will see these regional centers being totally self-supporting and no longer in need of any Federal support.

The new programs have clearly increased identification, have delivered services, and have actually cut costs. And it is for that reason that we are again supporting wholeheartedly the 3-year extension at the levels that this committee has recommended. Thank you.

Senator HATHAWAY. There has not been any funding for the blood separation centers for the last 2 years, and the President does not include any money for this year's budget.

Dr. ALEDORT. Well, there was a small amount that was supporting the separation center money, and we did support this pilot program and this investigation of the Booz, Allen & Hamilton study. We are not happy to see that it was not funded last year, and therefore all the money is in the treatment centers in this new fiscal year, October 1.

I do feel, from the data that we have collected, that there is need to put money into that piece of the legislation because of the problems in the lack of appropriate component therapy use, which was the reason for putting that piece of legislation in at the beginning. And I think that the fallout for other diseases goes well beyond just hemophilia—the leukemic platelet transfusion problems, the white cell transfusion problems, which are now being met by individual centers doing plasmapheresis on large numbers of family members, could be alleviated if the blood that was collected as whole blood—the 9 million units that are collected in this country—could begin to be used more effectively; we would not have to have these expensive plasmapheresis programs around. And we hope that money would continue to be put into that piece of the legislation to continue the efforts to get that to happen.

Senator HATHAWAY. So you support the authorization that is requested in the bill?

Dr. ALEDORT. Yes.

Senator HATHAWAY. Thank you very much. We appreciate your testimony.

Dr. ALEDORT. You are welcome.

Senator HATHAWAY. At this point I order printed all statements of those who could not attend and other pertinent material submitted for the record.

[The material referred to follows:]

Statement of the
Council of Home Health Agencies and Community Health Services
National League for Nursing
Submitted to the
Subcommittee on Health and Scientific Research
Senate Committee on Human Resources
on S.2474
March 10, 1978

The Council of Home Health Agencies and Community Health Services, in behalf of its 1500 Medicare-certified home health agencies, appreciates the opportunity to present our views on S.2474, the Health Services Extension Act of 1978. Our comments relate to Sec. 320, Home Health Services.

CHHA/CHS commends the sponsors of S.2474 for their recognition of the viability of home health services. In extending the authorization for the grant program through fiscal year 1981, you have once again demonstrated your support for a vital, but often neglected, component of the health care delivery system

The previous grant awards provided $6,000,000 in developmental and expansion grants, enabling HEW to fund 112 projects - 30 developmental and 82 expansion projects. Although an evaluation of this program is not yet completed, preliminary indications are that the program was successful in meeting its goal-to provide home health services in areas where such services are not otherwise available.

Indeed, a recently published report #OPEL 77-11, Home Health Grant Program Evaluation Methodology, states that:

> "Despite the differences that exist among these (home health) agencies in terms of tradition, philosophy, and staffing, it is apparent that each has been successful in using grant monies to increase services and the number of patients served and to become fiscally viable. It is also apparent that the grant money provided an opportunity for these agencies to meet community needs that otherwise would not have been met, by increasing the number of employees already on staff, by adding services, by expanding the service area, or, in the case of one agency, by underwriting the costs of care of patients who are unable to pay.
>
> "In addition, one characteristic of the current grant program was identified which, if modified, might enhance the effects of the grant program on the capacity development and financial self-sufficiency of home health agencies. In contrast to agencies located in major population centers, rural home health agencies frequently experience difficulty in identifying and hiring personnel qualified to provide the number and types of services

appropriate. Because, say, a physical therapist does not live in the service area, an agency may not be able to state honestly in a grant application that it expects to add a physical therapist if it receives a grant. On the other hand, if a physical therapist is located during the funding cycle, no grant money is available for adding this person to the staff. In most such cases, prospective employees are unwilling to wait for the home health agency to find necessary funding before deciding on employment opportunities provided by other health care organizations with the same service area.

"It has therefore been suggested to the administrator of the home health grant program that means be explored for making available to home health agencies, through the regional offices and on a noncompetitive basis, limited amounts of money for specific purposes, such as hiring an additional employee, conducting training programs, etc."

Our concern for the continued development of home health care is coupled with a distinct awareness of an increased need for continued education of agency personnel. In our September 1976 testimony presented during the HEW regional hearings on Home Health Care, we spoke of the dire need for training monies to upgrade and increase agency personnel to administer, implement and evaluate quality services.

We would like to have some wording in the committee report which indicates that the training monies can be used for either long-term or short-term grants. There is a pressing need to upgrade the skills of home health agency personnel in such areas as administration, fiscal and personnel management, management information systems and supervision. While some of these needs could be met through short-term training programs, we would like to see regulations written which would allow training monies to encompass continuing education offerings in a variety of settings up to an academic year of study.

As a final point, CHHA/CHS believes that monies must be made available to fund a project to establish national criteria for determining the need for home health services. We urge you to include an authorization of $500,000 in S.2474 for such a project.

We would like also to comment on the health planning bill currently under consideration in the Senate. The need for a federally mandated certificate of need has been demonstrated time and time again. With each passing day, increasing numbers of home health agencies are being certified to serve areas where need is not indicated, thus increasing the costs to the Medicare/Medicaid program made necessary by the funding of multiple administrative structures.

States' attempts to enact certificate of need legislation have failed or have been enacted only after certain urban areas are im... ated with agencies. Oftentimes, the state certifying agency recognizes that need for a new agency cannot be rationalized but it cannot deny certification without statuatory or regulatory justification. Such certificate of need must be applicable to all types of home health agencies.

CHHA/CHS is pleased to present its views and will be happy to provide further information, and/or documentation of these. We hope the committee will consider our comments carefully and favorably.

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NATIONAL LEAGUE FOR NURSING

Written Testimony
to the

SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH
ON HUMAN RESOURCES
U.S. SENATE

14 March 1978

We are the National League for Nursing, a coalition of nurses, other health professionals, consumers and health agencies--17,000 individual members and 1,900 agencies, dedicated to developing and improving the standards of quality nursing education, nursing services, and health care delivery in the United States--all of whom work together to help meet community nursing needs and to assure high quality nursing education. Among its functions, the League is officially recognized as the national accrediting agency for all nursing education programs by the Council on Postsecondary Accreditation (COPA) and the U.S. Office of Education.

Since the 1960's, the role of the Federal government in health care has been, in addition to expanding financing for the aged and poor, to expand the resources devoted to health. The effort can only be regarded as a success. The growth in the number of registered nurses, aided by Federal expansion of nursing schools as well as nurses' roles, has been dramatic.

But now, the Administration's perceptions and priorities are shifting. There is a concern that the health sector is growing too fast and that includes the supply of nurses.

Ten years ago, an increased supply of nurses and doctors, health planning, prospective reimbursements, PSRO's, were all regarded as solutions to the problem. But there is still the very stark reality that there is unequal access to the health care system, both to financing and to care itself.

The irony of the situation lies in the fact that just as nursing seems to be showing signs of success in terms of providing solutions to unequal access and rising costs, a new skepticism has surfaced on the part of the Administration. It would be a mistake to allow this skepticism to obscure the need for continued financial assistance to those portions of the health care system that are most promising with regard to cutting costs and increasing access. It will be to the benefit of us all if the Congress decides to make this short-term extension of Federal Funds in the interest of long-run reruns.

A discontinuation of funds at the time would be very disruptive to a great many schools who rely on these funds for major budget items.

The National League for Nursing has recently analyzed the results of a Special Study of Capitation Provisions of the Nurse Training Act of 1975, conducted by the American Nurses' Association, American Association of Colleges of Nursing and the National League for Nursing. The study surveyed public and private schools of nursing to determine primarily how the funds were used and what effects cessation of funding would have.

Among the schools surveyed the greatest percentage of funds was used for faculty salaries. In all three types of programs, faculty salaries was reported to be the highest item of expenditure with use of capitation funds. For example, out of $67,000 (average dollar amount received per Baccalaureate program), $45,900 (in average dollar amount per Baccalaureate program) was expended on faculty salaries. In many cases, discontinuing these funds would mean losing at least two or three faculty members. Now that schools have increased their enrollments so that they could be eligible for these funds, it would therefore be most unfair to students enrolled in these programs to abruptly discontinue the funds.

More than half of the schools stated that a reduction or discontinuation of these funds would have a severe impact on their programs. 71% of the Baccalaureate programs stated that they felt it would be crucial to continue these funds. Schools plan curricula years in advance, and often times these funds are an essential part of these plans.

Monies were also heavily depended upon, according to the survey, for continuing education and curriculum expansion. New programs are being supported by these funds, and in many cases, are not capable of sustaining the loss of federal support. In addition, many nurse practitioner programs, offered through continuing education departments, as well as through curricula initiated with federal dollars, would be affected. A cessation of funds at this time without a thorough evaluation of the need to continue

these programs would have damaging effects to the entire health care system, and to the students in these programs as well.

At the very least, perhaps a gradual phasing out of these monies could be accomplished once the overall requirements for nurse manpower have been accurately assessed. Select funding according to regions might also present a viable alternative.

The role of nurses in health encompasses not only professional practice and technical skills, but is inextricably related to the complexities of the entire health care system. In recent years our role has changed dramatically to meet the needs of a health care system undergoing widespread transformation. We wish to continue to address the problems in health care.

As a profession, we are committed to attaining a rational use of expensive resources as well as equitable quality of care. We have, in fact, made many inroads to the problems in maldistribution, primary care, and health education, to name a few.

In order to further direct our efforts toward providing remedies for the current health care crisis, we will need continued Federal support, and therefore, we strongly support the proposed two-year extension of the Nurse Training Act.

Representing the largest segment of providers, nurses are becoming involved in many new modes of health care delivery such as out-patient clinics, industries, schools, and primary care settings, as well as in the traditional hospital and community health settings. We are providing a wide range of new services including psychotherapy, counciling to families on death and dying, home health, physical assessment and health education.

To date, NLN's 1976 survey on newly-licensed registered nurses reports that 66.2% are still employed by hospitals with 3.9% by nursing homes and 9.9% falling into an "other" category. It seems reasonable to expect, however, that this trend may change. The growing trend toward non-institutional care will require nurses that are prepared in expanded roles. It will require nurses with a knowledge of economics, reimbursement procedures and above all sound decision-making abilities. As the data in this testimony will show, many nurses presently hold positions for which they are unqualified.

Thus, despite recent efforts and improvements, many gaps and omissions are apparent with regard to the nursing profession as well as to the entire health care system.

STUDIES UNDERWAY

We are currently engaged in efforts to identify these gaps and omissions for that is the first step toward solutions.

Section 951 of the Nurse Training Act of 1975, specifically requests information to be collected on a continuing basis regarding the current and future supply and distribution of nursing personnel, nationwide. In addition, it requests specific data including the supply and distribution of specialties, educational preparations, salaries, and activity statuses.

To meet these requirements a variety of studies funded by HEW are underway that will provide the data needed for sound decisions in all of these stipulated areas. However, these studies will necessitate additional time for completion due to the enormity of the task of integrating existing data as well as developing measures that will accurately reflect future trends in changing economic and social contexts.

The information that is presently available is fragmented, out-dated, and undifferentiated as to levels or types of practice. Another difficulty lies in the fact that as consensus has never been reached about how health status should be defined or how changes in health status should be measured. One means of determining nurse manpower requirements is to look at the need to improve, maintain, or restore the health status of the population. However, a lack of consensus as to a definition of health status has mitigated this approach. Steps to determine a measure of this concept are currently underway.

Models have been developed and are now being utilized in studies funded by HEW that will furnish the required data. (See attachment)*

* Among these is a national model that has been developed with the active involvement of a task force including representatives of nursing service, nursing education, comprehensive health planning, the Division of Nursing in DHEW, and Western Interstate Commission on Higher Education's nursing program staff.

The model is based on a set of techniques referred to as System Dynamics. A System Dynamics model describes a set of casual relationships responsible for changes in variables of interest to policy makers such as those variables characterizing the supply of, demand for and distribution of nursing personnel and services at the national level.

The data that are presented in this testimony are based on data collected up until and including 1972, from a variety of sources (American Nurses' Association, National League for Nursing, the American Hospital Association and HEW), to fulfill the requirements of the Nurse Training Act of 1975. Projections from 1975 to 1990 have been made as to supply, distribution and requirements by means of a special statistical formula called the "net attrition rate," whereby existing data on the total numbers of nurses and the number of graduates each year are interpreted on the basis of assumptions about the behavior of the derived net attrition rate. The graduation projections represent the net inputs into the nurse supply while the net attrition rate accounts for activity status (part-time, full-time, etc.), and foreign nurses inputs.

PROJECTIONS OF SUPPLY

HEW projects that by 1990 the number of those RN's available for employment would range between 1,467,000 and 1,541,000. About 62% of these would have as their highest educational preparation associate degrees or diplomas; 33% baccalaureate; and 5% masters or doctoral degrees.

In 1976, it was estimated that there were 961,000 RN's in the supply; 16% baccalaureate nurses and 3.4% masters or doctoral degrees.

A comparison of the estimates from 1976 and 1990 respectively, forecasts an increase of baccalaureate nurses from 16% to 33% of the nurse supply. A decline of 81% to 62% was projected for AD and diploma graduates. Masters and doctoral components would increase from 3.4% to 5.1% and 2% respectively.

When a state by state projection of supply in 1980 was considered, the overall picture revealed additional implications. The proportion of state's supply having only nurses whose highest education would be an associate degree or diploma predicted a decline by 1980 in all but five states. Nevertheless, this group will still represent a very sizable proportion of the total nurse supply. At least three-quarters of the

total nurse supply in half of the states will be composed of AD and diploma nurses by 1980. Therefore, given the increasing supply of nurses in each state, despite the decrease in the numbers of AD and diploma nurses, the number of nurses with those educational levels will still increase.

The proportionate supply of baccalaureate nurses will increase in all the states but four--Florida, Arkansas and the Dakotas. However, only in one-fifth of the states will the baccalaureate component equal at least 25% of the state's total supply in 1980.

While the master's and doctoral levels generally showed higher proportions by 1980, in most states they were still a very small proportion of the total supply.

PROJECTIONS OF DISTRIBUTION

State to state distributions, analyzed according to nurse per population ratio, have shown consistent increases over the years and future projections indicate a continuation of the trend.

The variation among states is very great, however; the difference between lowest and highest states being about three times as many RN's/100,000. The lowest ratios of RN's/100,000 population were projected in Alabama and Louisiana; the highest in Vermont and Washington, DC, ranging in the vicinity of 1,000 RN's/population.

While data of this nature is useful in determining trends, it is virtually meaningless unless related to the specific area requirements of each state including different specialties and levels of educational preparation. How the area's population receives its services also needs to be taken into consideration. These additional factors are currently being studied.

ASSESSMENT OF REQUIREMENTS

Preliminary assessments of requirements according to levels of educational preparation shed interpretive light on the overall picture.

The Western Interstate Commission for Higher Education, as part of its work on the project, "Analysis and Planning for Improved Distribution," has predicted what the appropriate mix of educational requirements should be, given current utilization patterns. Projections were made according to criteria established by the Surgeon General's Consultant Group on Nursing for appropriate educational attainment level for nurses serving in various capacities. One should keep in mind, however, that since the establishment of the criteria in 1962, nurses roles have become much more differentiated, and responsibilities have changed accordingly. Thus, these criteria are presently considered minimal educational criteria.

The number of employed registered nurses holding master's or doctoral degrees has been strikingly low. In 1972, 24,200 or 3% of employed registered nurses actually held masters or doctoral degrees and 107,200 or 13.7% had earned baccalaureate degrees. If employed RN's had the educational preparation that their positions warranted, 17% would have been employed at the masters or doctoral levels and 31% at the baccalaureate levels. Therefore, there should have been five times as many nurses with masters or doctoral degrees as there actually were in 1972; and twice the number of registered nurses with baccalaureates as their actually were.

In addition, when the educational preparation of employed nurses was considered on a statewide basis, (1972) none of the states had the number of baccalaureate, masters or doctorally prepared nurses that they should have (again, according to the Surgeons General Group criteria.) In fact, nine states needed ten times the number of nurses at that educational level than were in supply.

RECENT EVIDENCE

The need for advanced leadership preparation for nurses has been addressed by many experts as well as being documented in the literature.

A feasibility study conducted by Western Interstate Commission on Higher Education in 1976 to determine the need for the development of regional centers to give

advanced leadership preparation to nurses provides further evidence of this situation. The study surveyed schools and conducted on-site visits.

All of the schools surveyed indicated that they had unfilled faculty or administrative positions. The reason most frequently cited for this was a lack of appropriate educational credentials. Deficits included a lack of doctorates, clinical expertise and research skills.

Currently, there are many deanships in nursing programs and directors of nursing service positions that are vacant. Shortages exist in both functional areas: teaching and administration.

Faculty shortages have long been a problem in the nursing profession.

The National League for Nursing's 1976 Nurse-Faculty Census reports 776 budgeted vacancies. Regional variations were also evident in the League study. The vacancy rate is twice as high in the Midwest (295) as in either the North Atlantic (150) or West (62).

In the area of Administration, fewer than 15% of nurse administrators hold a masters degree or a doctorate. Members of search committees reported facing months of frustration as they struggled to fill Administrative as well as faculty spots. The shortage of nurses with appropriate Administrative education is particularly apparent in small rural hospitals and nursing homes.

According to Some Statistics on Baccalaureate and Higher Degree Programs, recently published by NLN, this trend seems destined to continue unless incentives are provided. While the number of students enrolled in graduate study is increasing, the percentage of graduate students enrolled in Nursing Administration is consistently decreasing. In 1968 there were 303 full-time masters students enrolled in Administration programs; and in 1976, there were 258 students enrolled. The percentage dropped to 3.8% in that year.

The number of graduate students enrolled in teaching programs has also declined. In 1968 there were 1,290 full-time students enrolled in teaching programs and in 1976 there were 1,323 enrolled.

The feasibility study also showed that some states had no masters or doctoral programs at all. This is quite indicative considering that NLN's Data Service on Newly-Licensed Nurses shows that they are most likely to be employed in the states where they attended school. One could easily hypothesize, then, that those states without masters programs might have the greatest shortages of specialized nurse supply.

To be sure, some progress has been made with Federal assistance through advanced nurse training funds. The overall number of doctoral programs as well as that of students has increased for the third academic year in a row. In addition, the proportion of full-time doctoral students increased for the first time since 1971-1972. Yet, despite additional programs, higher enrollments and greater proportions studying full time, doctoral graduations declined from 74 to 62.

A thorough assessment of the overall picture merits a note of caution: Planning cannot be done adequately and effectively on the basis of sheer numbers. The administration's appraisal that the nurse supply is adequate seems short sighted in light of these data projections. Leadership is imperative if nurses are to make a difference in the health of the people of this nation. It is imperative as practitioners, as educators and as decision-makers with the opportunity to participate in political processes, that we have more qualified nurses leaders.

NURSE PRACTITIONER

The nurse practitioner has been instrumental in addressing some of the deficiencies of health care in the United States. The utilization and acceptance of this new form of health manpower, in addition to enhancing the contribution of nursing in the planning and provision of health care, is expected to result in the improved quality of health care services.

Since nurse practitioners are such a new phenomena to the health care system, more time is needed to assess their total impact.

However, A Longitudinal Study of Nurse Practitioners, conducted and funded by NIH, has shown some pertinent findings.

The study identified 131 certificate-awarding programs and another 84 programs granting masters degrees. The major areas of specialization included Family Nurse Practitioners, Pediatric Nurse Practitioners and Adult Nurse Practitioners. Other major areas were women's health, community and mental health specialties.

The study demonstrated that many nurse practitioners practice in rural areas and that most are family practitioners, with more than 90% being certificate nurse practitioner graduates. These new professionals could very conceivably provide solutions to our problems with maldistribution and primary care. Thus far there is no national data of value to describe the impact of these practitioners on maldistribution of health care services. However, selected studies have demonstrated their cost effectiveness. For example, a study cited in the February '78 New England Journal of Medicine reported that average costs - including nurse practitioner time, charges for laboratory tests and medications, were 20 percent less.

These programs still require Federal support; many difficulties still need to be resolved before these programs can function without Federal dollars.

Many times the nurse practitioner encounters a situation that was not included in the Nurse Practitioner Curriculum, or she/he may be expected to practice seven days a week, with little relief. These situations must be rectified by providing more Federal incentives to practice in shortage areas. The additional monies proposed for Special Projects will be very helpful in this regard.

Up until now the market for these practitioners has been rather slow in terms of acceptance and demand for them. Now that nurse practitioners are eligible for reimbursement for service under the Social Security amendments, the volume and types of services provided will undoubtedly be greatly expanded.

If the nurse practitioner's function is to become more than a peripheral additive of fringe for the present system, and rather is to become part of an overall strategy for improving the quality and quantity of primary care services available, an extension

of Federal monies is essential. Three fourths of nurse practitioner programs in the Longitudinal Study offer some financial assistance through stipends or traineeships (77%); and, in many cases, availability of these monies is dependent upon federal dollars.

RESEARCH

All practitioners have ways of evaluating unknowns and various aspects of change.

Research in nursing approaches these areas in a manner which is very different from the medical disease model. Nursing research is concerned with a "holistic" model of man; that is, a model that does not treat mind and body as two separate entities. Nursing research is concerned with health promoting patterns in relation to the total behavior of the individual.

In this age of increasing complexity, many nurse researchers believe that a cause and effect, disease-oriented model is no longer adequate. Many disease processes such as cancer, for example, are beginning to be studied with regard to stressful events in the life of the individual.

Despite its short history, nursing research has already made valuable contributions to health care. However, Federal funding priorities have been oriented toward the cure of disease, rather than prevention, improvement in quality patient care, or basic research with other models.

In nursing, our concern is experimental; and there is no separateness of mind and body, psychosocial and biophysical. The nurse regards signs and symptoms of disease as manifestation of man's wholeness, for the patient is experiencing one event.

Nurse researchers have made major breadthroughs in basic as well as applied research. The nursing profession has a significant contribution to be made; however, there are very few nurses adequately prepared to do research. Out of approximately 1,500 nurses in the United States who have earned doctorates, only 30% are engaged in research.

A ratio of graduate and undergraduate students per biomedical and behavioral Ph.D. scientists employed in academic settings ranged from approximately 20:1 to 40:1 between 1960 and 1972. On the other hand, a 1974 ratio of full-time graduate students for each full-time nurse faculty member holding a doctorate was 158:1.

In view of the current national concerns in health care, it is necessary that federal support of health related research include nursing studies. The problem of quality assurance, health maintenance and prevention of disease need to be addressed through the support of research in nursing. The lack of clinical research, the area which investigates patient phenomena encountered by nurses and for which nurses are expected to initiate appropriate intervention, is a very real deterrent to positive change and progress. To achieve progress, nursing must be given the opportunity to explore a changing concept of health through basic, as well as applied, research. More of the same is clearly not the answer. We need the financial assistance to explore new solutions to old problems.

THE FUTURE

We are indeed witnessing the limits of modern medicine. While tremendous strides have been made, there have been very serious negative repercussions. The toll that medical technology and specialization have taken on costs is profound. The drastic rise in costs have also occurred as a result of the highly trained specialists required to use this equipment for diagnostic and curative purposes.

Medical care decisions have increasingly been made without the slightest regard for costs vs benefits. Key examples can be seen in the areas of kidney dialysis and increased use of intensive care units.

The consumer movement, the self-care movement, and the increasing involvement of the Federal government in health care all herald new trends.

In the midst of these changes, the concept of the expanded role of the nurse has been introduced in response to the growing needs of the health care system. With changes in the priorities of their duties and a willingness to accept new responsibilities, nurse manpower has presented some very viable alternatives to many problems that the health care delivery system faces. Nurses provide care at the lowest level of technology, meet the emotional requirements of patients for counseling and support in an age of ennui and depersonalization, provide health education (as they have always done), in whatever role she/he functions.

The enactment of many new legislative proposals is on the horizon for health care. Health planning legislation, the HMO amendments, national health insurance and the coming of age of home health care will evoke new needs and requirements for nurse manpower. Nurses must be prepared for these plans now. Needs for nurse manpower supply must be viewed in the context of the projected political and financial settings. As different trends take shape, objectives and assumptions must change to meet different needs.

Whatever future trends may be projected, registered nurses presently form by far the largest group of health professionals. Their increasingly differentiated roles has led to greater responsibilities and independence in practice. These new roles warrant more leadership preparation, an element which is currently a scarce commodity in the nursing profession, as we trust was communicated by the data in this testimony.

Mr. Chairman, thank you for the opportunity to testify and we hope that you will continue, as you have done in the past, to assist nursing to maximize its contribution to health care.

Sources of information: all statistics in this testimony were documented by the HEW Division of Nursing, the NLN Division of Research and the Western Interstate Commission on Higher Education.

ATTACHMENT I

To fulfill the need for requirement projections prior to the enactment of Public Law 95-63, the Division of Nursing launched four studies concerned with the projection of nursing resources and requirements. Since requirements can be approached from several points of view (i.e., demands, needs, or wants) it was important to examine a variety of approaches.

The different models and a brief summary of the methods and purposes utilized in each of the studies follows:

1. A Model of National Supply and Requirements for Nursing Personnel. (Pugh-Roberts Associates, Inc.)

   This effort is directed from a national perspective toward the analysis of factors affecting nursing requirements and resources from the present through the year 1990. The technique used for the development of this model, known as System Dynamics, describes a set of causal relationships responsible for changes in pertinent variables. As part of this approach, a series of issues or particular relevance to the questions surrounding supply and requirements is being developed. These will be used in the overall analysis of impacts on supply and requirements, particularly from a long-range viewpoint.

2. An Analysis of the Impact of Nurse Manpower Requirements of Changes in the National Health Care System. (Vector Research, Inc.)

   This work was directed toward the assessment of the impact of three anticipated changes in the health care system on the requirements for nurses: (1) the introduction of National Health Insurance; (2) the increased enrollment in Health Maintenance Organizations;

and (3) the reformulation of nursing roles. The model predicts requirements for nurses under various alternative assumptions surrounding these subjects with one developed as "most probably." Projections are based on a 10-year time frame. The first analysis level is on a national basis with subsequent application of the approach to the State level.

3. Analysis and Planning for Improved Distribution of Nursing Personnel and Services: State Model. (Western Interstate Commission for Higher Education)

This effort is being directed toward the systematic use of data available on a national basis, but capable of being disaggregated to State and county levels, to determine nursing resources and requirements. The approach being designed is one that would allow for practical application at the State level. Projections will be made for a 5-year period since that time frame is best suited to a trend approach. Since this activity is most specifically directed to the State level, it will form the basis of the first-level analysis on the numbers of nurses available and the numbers required in each State. The impact of these individual State data nationally will be examined through the application of uniform criteria in each State. Since the areas that are being addressed in this activity are particularly relevant to overall health planning as well as to nurse requirements, this will be incorporated into the overall analysis to provide additional insight into the effects of the delivery system on nurse requirements.

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4. Micro-Model for Nursing Manpower Needs. (CSF, Ltd.)

The model is intended to incorporate demand and supply factors into a framework for determining nursing manpower requirements on a sub-State level. It will have a capability for annual requirement projections over a 10-year period. The model incorporates three submodels: health services utilization, nursing manpower demand, and nursing manpower supply. It will take into account registered nurses, licensed practical nurses, and nursing aides/attendants/orderlies. The supply model will be on a county level and requirements will be developed on an institutional and county level.

These modeling efforts will not only serve the important purpose of furthering the analytical capability for this series of reports, but will have wider application. In the development of approaches and in the consideration of outcomes, particular attention has been paid to the need for effective tools at other levels. Thus, it is anticipated that, in addition to the actual generation of requirements estimates from a Federal viewpoint, the processes will be developed in a way that could provide material appropriate for consideration by States and the newly developing Health Systems Agencies in their planning.

NATIONAL ASSOCIATION OF FARMWORKER ORGANIZATIONS
1329 E Street, N.W., Suite 1145
Washington, D.C. 20004

202-347-2407

February 22, 1978

Dr. Karl Shapiro
Subcommittee on Health &
Scientific Research
Committee on Human Resources
Room 4230
Dirksen Senate Office Building
Washington, D.C. 20510

Dear Dr. Shapiro:

Enclosed please find written testimony that NAFO wishes to submit for consideration in the development of S. 2474, the Health Services Extension Act of 1978.

Should you have any questions with the testimony or require any additional information, please feel free to contact either myself or Sandy Breedlove at the above number.

Sincerely,

Eliezar P. Vecchio
Director of Health & Education

I WISH TO THANK THIS SUBCOMMITTEE FOR THE OPPORTUNITY TO ADDRESS THE HEALTH NEEDS OF FARMWORKERS AND THE EXTENSION OF THE MIGRANT HEALTH PROGRAM.

FARMWORKER FAMILIES, PARTICULARLY THOSE WHO FOLLOW SEASONAL EMPLOYMENT, HAVE BEEN TRADITIONALLY EXCLUDED FROM THE TYPICAL SYSTEMS OF BOTH PRIVATE AND PUBLIC HEALTH CARE. AMONG THE BARRIERS THAT IMPEDE THE FARMWORKER FAMILY'S ACCESS TO EVEN THE MOST FUNDAMENTAL FORMS OF HEALTH CARE ARE:

- LACK OF PURCHASING POWER;
- MIGRATORY EMPLOYMENT WITHIN ISOLATED, RURAL AREAS (LACK OF HEALTH PERSONNEL, INCONVENIENT HEALTH FACILITY HOURS, LIMITED TRANSPORTATION, INCONTINUITY OF CARE, ETC.);
- LIMITED EDUCATION, RESULTING IN LACK OF CONSUMER KNOWLEDGE AND VULNERABILITY;
- DISCRIMINATION, RESULTING FROM BEING POOR, A MEMBER OF A MINORITY GROUP, AND/OR INABILITY OR LIMITED ABILITY TO SPEAK ENGLISH; AND
- SPECIAL HEALTH CHARACTERISTICS, PARTICULAR TO THE FARMWORKER POPULATION (ENVIRONMENTALLY-INDUCED CONDITIONS SUCH AS PESTICIDE POISONING, NUTRITIONAL DEFICIENCIES, HYPERTENSION, TUBERCULOSIS, ETC.),

THE MIGRANT HEALTH ACT, INITIATED BY CONGRESS IN 1962 IN AN ATTEMPT TO ADDRESS THE UNMET HEALTH NEEDS OF FARMWORKERS AND THEIR FAMILIES, FOCUSED ATTENTION ON THE UNIQUE HEALTH NEEDS OF THE MIGRANT POPULATION, NECESSITATING A SPECIAL SYSTEM OF HEALTH CARE DELIVERY. THE ACT WAS REFINED AND IMPROVED IN 1965, 1970, AND 1973 BY AMENDMENTS DESIGNED TO EXPAND SERVICES TO PROVIDE HOSPITAL CARE, EXPAND COVERAGE TO SEASONAL FARMWORKERS, AND REQUIRE POLICY LEVEL INPUT BY THE CONSUMER.

MIGRANT HEALTH CENTERS AND PROJECTS HAVE BECOME THE PREDOMINANT HEALTH CARE PROVIDERS FOR THE FARMWORKER POPULATION -- IN MANY CASES THE ONLY PROVIDERS. HOWEVER, IT IS --

- BECAUSE THE INITIAL BARRIERS TO HEALTH CARE STILL EXIST;
- BECAUSE HEALTH CARE NEEDS STILL REMAIN UNMET; AND
- BECAUSE PROBLEMS WITHIN THE MIGRANT HEALTH PROGRAM CONTINUE TO BE IDENTIFIED.

THAT THE NATIONAL ASSOCIATION OF FARMWORKER ORGANIZATIONS (NAFO) URGES THIS SUBCOMMITTEE TO CONSIDER THE FOLLOWING IN LIGHT OF S. 2474, THE HEALTH SERVICES EXTENSION ACT OF 1978.

AUTHORIZATIONS

LACK OF PURCHASING POWER, THE FARMWORKER'S PRIMARY OBSTACLE IN OBTAINING HEALTH CARE, IS ALSO THE MIGRANT HEALTH PROGRAM'S MAJOR DEFICIENCY IN PROVIDING HEALTH CARE SERVICES TO THE ELIGIBLE FARMWORKER POPULATION. NO PROGRAM, REGARDLESS OF INTENT, DESIGN, OR COMPETENCY OF STAFF, CAN DELIVER COMPREHENSIVE SERVICES WITH AN INSUFFICIENT FUNDING BASE.

OF STAFF, CAN DELIVER COMPREHENSIVE SERVICES WITH AN INSUFFICIENT FUNDING BASE.

MIGRANT HEALTH CENTERS HAVE INDEED DEMONSTRATED A POSITIVE RECORD OF ACHIEVEMENT IN REDUCING THE OVERALL COST PER PATIENT VISIT, INCREASING THIRD-PARTY REVENUES, AND EXPANDING SERVICES TO THE FARMWORKER POPULATION. AND YET, 80% OF THE ELIGIBLE FARMWORKER POPULATION IS NOT SERVED THROUGH THE MIGRANT HEALTH PROGRAM -- AND, IS UNLIKELY TO BE SERVED OUTSIDE OF IT. TO RENDER ADEQUATE HEALTH SERVICES TO THE 2.7 MILLION FARMWORKERS PLUS DEPENDENTS, USING EXISTING FUNDS, MIGRANT HEALTH CENTERS AND PROJECTS WOULD HAVE TO SUBSTANTIALLY REDUCE COSTS PER PATIENT VISITS -- AS WELL AS HIRE "MILAGROSOS", MIRACLE WORKERS.

IT HAS BEEN ESTIMATED IN PREVIOUS CONGRESSIONAL HEARINGS THAT THE MIGRANT HEALTH PROGRAM REQUIRES ANYWHERE FROM $215 - $600 MILLION TO RENDER ADEQUATE HEALTH CARE TO ALL QUALIFYING INDIVIDUALS.

1. WE URGE THIS SUBCOMMITTEE TO AUTHORIZE THE FOLLOWING FUNDING LEVELS THROUGH FY1983 FOR MIGRANT HEALTH:

	PLANNING	OPERATION	HOSPITALIZATION
FY 1979	$ 10 MIL.	$ 100 MIL	$150 MIL.
FY 1980	11 MIL.	110 MIL.	165 MIL.
FY 1981	12.1 MIL.	121.1 MIL.	181.5 MIL.
FY 1982	13.3 MIL.	133.2 MIL.	199.7 MIL.
FY 1982	14.6 MIL.	146.5 MIL.	219.7 MIL.

2. We also urge this Subcommittee to consider administrative alternatives within the migrant health program to utilize existing monies more efficiently and hold the program more accountable to the people it serves.

A. Rural Health Initiative

NAFO cannot sanction the use of limited migrant health monies to fund RHI programs, and asks that HEW be held more accountable for those funds mandated to migrant health care. In FY 1977 alone, $4.5 million, or roughly 13% of the total migrant health funds, were conscripted for use in the RHI.

Consider the relationship between source of funding and population use in the following three RHI programs during FY 1976 according to HEW figures:

- At an RHI center in Florida, 22.5% of the total health services provided were used by migrant and seasonal farmworkers. However, 84% of the program's total funds were derived from migrant health monies.
- An RHI center in Texas, provided 46.6% of its total services to farmworkers, while 81.4% of the program's total funds were acquired through migrant health funds.
- In California, 43.3% of an RHI program's total services provided were utilized by migrant and seasonal farmworkers; 87% of the total funding was received from migrant health. (SEE APPENDIX A FOR MORE DETAILED ANALYSIS).

Migrants lose more than money to the Rural Health Initiative - they also lose the control of the program in relating services to need through a very limited level of policy input. Farmworker-governed boards, a mandated component of the migrant health center, are replaced by broad consumer boards in the RHI program. In 1976 only 1 (one)

OUT OF 138 (ONE HUNDRED THIRTY-EIGHT) RHI GRANTS WENT TO A FARMWORKER-GOVERNED HEALTH PROVIDER. LIMITED BILINGUAL OUTREACH AND SERVICES, MINIMAL COMMUNITY EDUCATION PROVIDED TO FARMWORKERS, AND UNDER-UTILIZATION OF SERVICES BY THE FARMWORKER ARE THE END RESULTS. STATED VERY SIMPLY, THE FOCUS ON FARMWORKER HEALTH NEEDS AS UNIQUE FROM THOSE OF THE LARGER POPULATION, IS SUBSUMED UNDER A SYSTEM DESIGNED TO DELIVER SERVICES TO A BROADER GROUP OF INDIVIDUALS -- THE VERY REASON FOR THE ESTABLISHMENT OF THE MIGRANT HEALTH PROGRAM IN 1962.

UNTIL THERE IS A CONCRETE FORMULA FOR FUNDING RHI PROGRAMS OUT OF MIGRANT MONIES, BASED UPON ACTUAL USE OF SERVICES BY SEASONAL AND MIGRANT FARMWORKERS, AND UNTIL THERE IS AN APPROPRIATE MECHANISM TO ENSURE ADEQUATE POLICY INPUT BY THE FARMWORKER, THE FLOW OF MIGRANT MONIES INTO THE FHI MUST BE STOPPED.

B. CONSOLIDATION OF PUBLIC HEALTH SERVICE (PHS) AUTHORIZATIONS

WE UNDERSTAND THAT THE HOUSE SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT IS CONSIDERING A CONSOLIDATION OF PUBLIC HEALTH SERVICE MONIES. BASED UPON THE FUNDING REALITIES OF THE RHI AND OTHER "INTEGRATED" SYSTEMS OF HEALTH CARE FINANCING, WE FORSEE NO BENEFIT OF SUCH A CONSOLIDATION OF FUNDS FOR MIGRANT HEALTH. IN FACT, WE VIEW SUCH A CONSOLIDATION AS ENCOURAGING A POLITICIZED DISTRIBUTION OF FUNDS AMONG THE PUBLIC HEALTH PROGRAMS AND A GRAVE THREAT TO THE CONTINUING EXISTENCE OF MIGRANT HEALTH PROGRAMS.

WE STRONGLY URGE THIS SUBCOMMITTEE TO MAINTAIN SEPARATE AUTHORIZATION LEVELS FOR THE PHS PROGRAMS AND ESTABLISH A MECHANISM TO ENSURE THAT MIGRANT HEALTH PROGRAMS RECEIVE COMPARABLE FUNDING INCREASES AS OTHER PUBLIC HEALTH SERVICE PROGRAMS, PARTICULARLY COMMUNITY HEALTH CENTERS.

C. Coordination of Federal Initiatives in Farmworker Health

P.L. 93-644, Section 5(b) gives CSA authority to coordinate, review, and monitor Federal migrant programs. We urge the Subcommittee to find out why this coordinating mechanism is not functional, and consider funding CSA to perform this responsibility, if in fact, lack of funding is the problem source.

A linkage must be developed among the Department of Agriculture (WIC, Summer Feeding), the Department of Labor (CETA), HEW (Title I of the Migrant Education Progarm, maternal and child health), and the Department of Transporation (rural transportation funds) for more effective and efficient use of resources.

- As the coordinator, CSA must consider the following:
- All programs administered through the state local agencies, should address and include farmworkers in their plans;
- A community education plan must be developed to inform farmworkers and farmworker agencies of available resources and enrollment procedure; and
- All farmworker health grantees (Sec. 319) should be encouraged to utilize other existing programs as well.

NAFO also recommends that the federal government assume a strong leadership role in placing pressure on states, localitites, and most importantly, the employer, to accept more responsibility in providing health care to farmworkers.

D. Fiscal Management of Special Migrant Health Projects

Given the limited resources available for migrant health, we would like to see the Office of Migrant Health, BCHS, explore more cost effective approaches in the delivery of health care to migrants, part-

ICULARLY IN THE HOSPITALIZATION AND ENTITLEMENT PROGRAMS. WE SUGGEST THAT THE OFFICE FIND ADMINISTRATIVE ALTERNATIVES TO THE USE OF BLUE CROSS/BLUE SHIELD AS THE FISCAL INTERMEDIARIES IN THE INTERSTATE ENTITLEMENT PROGRAMS, AND EXPLORE CONTRACTUAL ARRANGEMENTS WITH HOSPITALS, USING REIMBURSEMENT RATES MORE COST-EFFECTIVE THAN THE HOSPITAL'S OWN UCR (USUAL AND COSTOMARY CHARGE).

I WILL NOW DIRECT MY REMARKS TO THOSE CONCERNS THAT MORE DIRECTLY AFFECT THE INDIVIDUAL OPERATION OF AND SERVICES PROVIDED BY THE MIGRANT HEALTH CENTERS AND PROJECTS THEMSELVES.

ELIGIBILITY

TO QUALIFY FOR SERVICES PROVIDED UNDER SECTION 319, RECIPIENTS MUST MEET RESIDENCE AND WORK CRITERIA. BECAUSE THERE IS NO FUNCTIONAL DEFINITION OF FARMWORKER, THE FOLLOWING ARE EXCLUDED FROM RECEIVING HEALTH CARE BENEFITS:

- OLDER AND/OR DISABLED FARMWORKERS WHO CAN NO LONGER WORK IN THE FIELDS;
- FARM WORKING CHILDREN WHOSE PARENTS ARE POOR SMALL FARMOWNERS; AND;
- LOCAL CHILDREN ENGAGED IN SEASONAL FARM LABOR WHOSE PARENTS ARE UNEMPLOYED.

A NATIONAL DEFINITION OF FARMWORKER MUST BE DEVELOPED, FLEXIBLE ENOUGH, SO AS NOT TO EXCLUDE THOSE INDIVIDUALS FROM RECEIVING MIGRANT HEALTH SERVICES THAT ARE LEGITIMATELY EMPLOYED AS FARMWORKERS, HAVE SPENT THE GREATER PORTION OF THEIR WORKING LIVES AS AGRICULTURE LABORERS, OR HAVE BECOME DISABLED AS A FARMWORKER.

BCHS Funding Formula

The cost of providing medical care varies significantly from region to region. Those regions where fewer farmworkers reside and networks of migrant health centers are not apparent will have higher costs for necessary transporation and outreach services. In addition, the cost of living varies from one region to another. And yet, the BCHS funding formula is based totally on the number of farmworkers within the area and the number of clients served.

We suggest that BCHS takes into account the varying health needs of farmworkers in different geographic areas - variances in climate, crops, cost of living, and population distribution - and develop more flexible and equitable farmworker health grants.

National Health Services Corps

With the large numbers of Spanish-Speaking, Asian, and Arabic farmworkers, communication barriers and lack of cultural understanding often result in underutilization of available farmworker health services.

We recommend that the National Health Services Corps be particularly sensitive to culture and language when training health personnel for placement in medically underserved areas. Health personnel assigned to migrant health centers and projects should come into their placement with an understanding of the population they will serve - primary language, cultural background, and living and working conditions. All efforts should be made to solicit the involvement of Spanish-speaking individuals and others, conversant in needed languages, in the National Health Services Program.

National Advisory Council for Migrant Health

In order to ensure accountability and responsiveness to farmworkers in this Nation, NAFO recommends expansion of the authority and role of the National Advisory Council for Migrant Health, including:

- Recognition of NACMH as the focal point for dialogue between HEW and the farmworker community;
- resources to hire staff to provide necessary planning, review and oversite responsibilities;
- resources to conduct four regional meetings per year in order to evaluate HEW's efforts in providing health care to farmworkers; and
- responsibility of NACMH to submit an independent evaluation of HEW's Migrant Health Program yearly to the Secretary, DHEW.

In order to ensure representation of farmworkers throughout the Nation NACMH should be composed of active migrant and seasonal farmworkers from each of the ten (10) federal regions selected by farmworker-governed health projects within each Region, five (5) representatives from various health professions and occupational areas, and a representative from the Migrant Division of BCHS and a representative from the Secretary.

In closing, I wish to again point out that the track record for the Migrant Health Program has been a good one. However, with sufficient funding and a firm mechanism in place to assure that the program is both responsive and accountable to the farmworker, the program can begin to reach more than the current 15-20% of the medically underserved population.

Thank you.

(APPENDIX A)

MIGRANT AND SEASONAL POPULATION V. ACTUAL USE BY MIGRANTS IN CERTAIN HEALTH PROJECTS

NAME AND REGION	POPULATION IN COUNTY [1] MIGRANT	SEASONAL	TOTAL	ACTUAL USE BY: [2] MIGRANT	SEASONAL	OTHERS	TOTAL
1. *Oak Orchard Community Brockport, N.Y. Reg. 2	1,126	298	1,324	323 or	23 or	1,420 or	1,766
	% of users to total pop [3] 16.58%			18.3%	1.3%	80.4%	
2. *Community Health of S. Dade Miami, Fla. Reg. 4	11,000	9,000	20,000	1,557 or	1,158 or	9,338 or	12,053
	% of users to total pop. 15.08%			12.9%	9.6%	77.5%	
3. State Bd. Of Hlth. Charleston Co. Hlth, Charleston, S.C. Region 4	350	900	1,250	19 or	38 or	271 or	328
	% of users to total pop. 1.49%			5.8%	11.6%	82.6%	
4. *Darke-Mercer-Shelby Reg. Hlth Service Greenville, Ohio Reg. 5	2,141	1,571	3,712	291 or	0 or	1,381 or	1,672
	% of users to total pop. 11.64%			17.4%	0.0%	82.6%	
5. *South Plains Health Provider Plainview, Texas Reg. 6	15,735	4,350	20,085	2,181 or	1,004 or	3,654 or	6,839
	% of users to total pop. 9.81%			31.9%	14.7%	53.4%	
6. *Jim Hagg Cty. Migrant Health Rio Grande City, Tex. Reg. 6	739	85	824	61 or	104 or	179 or	344
	% of users to total pop. 26.07%			17.7%	30.2%	52.0%	
7. Program de Salud de Northern Col. Gill, Colorado Reg. 8	1,668	6,586	8,254	213 or	81 or	475 or	769
	% of users to total pop. 2.22%			27.7%	10.5%	61.8%	
8. Maricopa Co. Health Dept. Phoenix, Ariz. Reg. 9	2,395	12,326	14,721	106 or	350 or	1,907 or	2,363
	% of users to total pop. 0.0%			4.5%	14.8%	80.7%	
9. *Orange Cove Family Health Orange Cove, Ca. Reg. 9	36,040	58,323	94,363	1,285 Or	498 or	2,330 or	4,113
	% of users to total pop. 5.57%			31.2%	12.1%	56.6%	
10. *N. Sacramento Valley Health Project Reg. 9	3,731	-	3,731	126 or	598 or	1,231	1,955
	% of users to total pop. 4.8			6.4%	30.6	63.0	

MIGRANT AND SEASONAL POPULATION V. ACTUAL USE BY MIGRANTS IN CERTAIN HEALTH PROJECTS

NAME AND REGION	POPULATION IN COUNTY			ACTUAL USE BY:			
	MIGRANT	SEASONAL	TOTAL	MIGRANT	SEASONAL	OTHERS	TOTAL
]]. +Community Health Clinics, Inc. Nampa, Idaho Reg. 10 .	9,333	1,522	10,855	299 or	480 or	2,000 or	2,779
	% of users to total pop.		9.74%	10.8%	17.3%	72%	

*RHI Projects
+HURA Projects
Unmarked are Migrant Health Projects

1 Table J, 1973 Migrant Health Target Population
2 Table 1, 1975 Migrant Health Projects, Summary of Project Data, Migrant Health Report 4.
3 Table 12, 1975 Migrant Health Projects, Summary of Project Data, Migrant Health Report 4.

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MIGRANT/RHI PROJECTS
F.Y. 1976

	319 Funds MIGRANT HEALTH PROGRAM	330 Funds COMMUNITY HEALTH CENTERS	RHI
Region I 1			
Washington Co. Health Plan			89,070
Region II 3			
Oak Orchard Community Referral			200,000
Puerto Rico Dept. of Health Western Region			162,982
Commonwealth of Puerto Rico Dept. of Health			200,000
Region III 1			
Intercounty Health Inc.	81.574		198,621
Region IV 4			
Collier Co. Health Dept. W. Orange Farmworkers Hlth. Clin	172,794	312,940	
Florida Rural Health Services Frostproof, Florida			230,931
Community Health of So. Dade	725,651		143,550
Region V 2			
Darke-Mercer-Shelby Regional Health Services	50,000		200,000
Sparta Health Center	30,000		200,000
Region VI 7			
Gonzales Co. Med. Society	175,253	15,000	
Catholic Charities Inc.	912,509	450,000	
Hidalgo Co. Hlth. Care Corp.	701,500	186,768	
Community Action Council	253,265		103,175
Home Education Livelihood Prog.	50,000		185,000
South Plains Hlth. Provider Org.	435,913		99,388
Southwest Migrant Association	275,000		192,289
Region IX 4			
Merced Family Health Center	372,000		200,000
Orange Cove Health Center	1,335,381		200,000
Yuma Co. Migrant Health Center	100,000		194,000
Clinica Sierra VIsta, Lamont, CA			
22	5,770,840	964,708	2,799,006

AMERICAN MEDICAL ASSOCIATION
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JAMES H. SAMMONS, M.D.
Executive Vice President
(751-6200)

March 8, 1978

The Honorable Edward M. Kennedy
Chairman
Subcommittee on Health and
Scientific Research
Committee on Human Resources
United States Senate
Washington, D. C. 20510

Dear Senator Kennedy:

The American Medical Association submits the following statement on the extension of certain programs under the Public Health Service Act and the Lead-Based Paint Poisoning Prevention Act.

The AMA urges the reauthorization of certain of these programs at appropriate levels. Although we believe that several provisions of the law pertaining to programs should be amended, it is our understanding that the Committee is now considering only an extension of most of the expiring provisions, and that consideration of substantive revisions of programs will occur at a later time. Therefore, we will reserve any specific suggestions for change to these programs until their later consideration by the Subcommittee.

We request that this statement be made part of the Subcommittee's record on S. 2474.

Sincerely,

James H. Sammons, M. D.

Enclosure

28-386 O - 78 - 17

Statement

of the

AMERICAN MEDICAL ASSOCIATION

Re: S. 2474, Health Services Extension Act of 1978

Submitted to the

Subcommittee on Health and Scientific Research
Committee on Human Resources

United States Senate

March 8, 1978

The Subcommittee on Health and Scientific Research is presently considering extensions of several health programs contained in the Public Health Service Act.

The Public Health Service Act is a major vehicle for much of the Federal funding of health programs throughout the country. The Act authorizes a variety of general grant programs with wide latitude for the direction of the programs to be taken by the recipient. Programs expiring this year include those directed toward providing certain health services (such as community health centers, migrant health and others) and also include programs in basic and applied research, data collection and other health activities. S. 2474 contains only a few of these expiring programs and we will address other expiring programs when commenting on the bills pertaining to them.

We have reviewed the programs to be extended, many of which we have supported from their inception. While we remain supportive of most of these activities and urge that you favorably consider extending them, we have also indicated those which we believe should not be continued. Although we believe

that substantive changes should be made to certain of the programs for which we recommend continuation, it is our understanding that such changes will not be considered by Congress at this time. However, we would be happy to work with the Subcommittee in developing needed amendments and will reserve our comments and detailed suggestions until that time.

Our comments on programs now being considered by the Subcommittee follow.

1) Comprehensive Public Health Services and Hypertension Programs

This is a block grant program for the states and allows each state wide latitude in selecting how the money will be distributed. Frequently, these grants supply the sole Federal support for many activities of the state public health services.

The AMA has supported this block grant program since its inception in 1966. The provisions of the law have served to ameliorate many of the difficulties that characterized the system of categorical grants which existed prior to the enactment of this program. These block grants to states have permitted each state to meet its particular needs by establishing its own priorities.

We support a one-year extension of this program at funding levels authorized in prior years.

We note that a new provision also provides funding for establishing and maintaining state programs for the screening, detection, diagnosis, prevention, and referral for treatment of hypertension (this was formerly part of the block grant program).

We support continued efforts to deal with the problems of hypertension.

2) Migrant Health

The health problems of migrant workers and their families are acute and delivery of services often requires Federal participation. The provisions which

are considered for extension authorize the Secretary to provide grants to public and non-profit private entities for projects to plan, develop and operate migrant health centers. These centers are to provide primary and supplemental health services to migratory and seasonal agricultural workers and their families. Also authorized are contracts with states for the implementation and enforcement of acceptable environmental health standards in migrant labor camps.

Over the years, the AMA has consistently supported Federal efforts to expand the availability of health services to migrant workers. We have pointed out, however, that the development of a federally supported program utilizing voluntary health insurance would be the most appropriate means of providing health care to migrant workers. One of the concerns over the present program that has been expressed is an undue reliance on migrant health centers as the method of providing services. Such stationary centers may in fact be too inflexible to cope with the needs of a migratory population. Appropriate changes should be considered at a later date. The extension of the program for five years without a detailed review is, we believe, inappropriate. A simple extension should be for only one year.

However, we do believe that the program has helped to provide health services to the migrant worker and should be continued pending intensive review. Therefore, we urge a one year continuation.

3) Hemophilia Program

This program provides funding for grants for establishing comprehensive hemophilia treatment centers and blood separation centers.

The AMA believes that the inclusion of these provisions in the PHS Act is unnecessary. We believe that private and other public programs have adequately cared for those persons with hemophilia and can continue to provide quality care.

We believe that increased support for basic research would be a more productive use of Federal funds and would, in fact, benefit many people in addition to hemophiliacs. Consequently, we urge that this provision not be extended.

4) Immunization and Disease Control and Venereal Disease Control

These programs provide federal funds to assist state programs of immunization against infectious diseases, control of diseases borne by rodents, prevention and control of venereal disease and other disease control programs.

These activities represent a major federal-state collaboration to prevent the spread of infectious and other diseases. The AMA has been supportive of these efforts and urges their continuation.

We commend to the Congress a child immunization bill recently drafted by the AMA. We believe this bill would enhance current efforts to increase the immunization levels among children and we urge its adoption. However, adoption of these amendments would not be inconsistent with present efforts, and we support a continuation of the existing immunization program.

Likewise we support the extension of the venereal disease control provisions. This program has played an important role in combatting one of the most widespread of communicable diseases and should continue. We do urge, however, that increased emphasis be placed on development of an immunization against venereal diseases. Such a development would prove the most effective use of federal funds in the long run.

5) National Health Service Corps

S. 2474 extends for one year and increases the funding level for the National Health Service Corps program.

We support this program and urge favorable consideration of this extension provision.

6) Community Health Centers

We note that the Community Health Centers program would be extended for five years and that new provisions would be added to fund "primary care units" of urban community hospitals for purposes of providing medical care to populations designated as having shortages of personal health services.

The Community Health Centers program is one in which special evaluation should be made of its effectiveness and the extent it has duplicated other existing resources. The program should be carefully evaluated before consideration of lengthy extensions or significant new provisions. Consideration should be given to incorporating these funds as part of a block grant to the states with wide latitude provided to the states as to how they distribute the funds. Therefore, we urge that no extension to the program be of more than one year and that adoption of new provisions be delayed until after an analysis of the existing program can be conducted.

7) Lead-Based Paint Poisoning

This program provides for identification and removal of lead-based paint hazards in buildings.

We support the extension of this program.

8) Genetic Diseases

The provision provides funds for programs to screen and counsel those with genetic diseases. It also funds educational and informational programs in this area.

We support a one year extension of these activities as proposed in S. 2474.

9) Home Health Services

These funds are used to provide grants to develop home health services and to train the personnel needed to provide these services.

Home health care can be an effective mechanism for caring for many people who need medical assistance but do not require hospitalization. S. 2474 would extend these programs for three years; however, we believe that the programs should be evaluated before a lengthy extension is adopted. We support a one year extension of these grants.

Conclusion

In conclusion, we reiterate our support for a one year extension of the following health programs expiring this year: comprehensive public health services, migrant health services, National Health Service Corps, Lead-Based Paint Poisoning prevention, immunization and disease control programs, venereal disease control, genetic disease activities, home health services and community health centers.

Substantive changes to certain programs are warranted, and we again would be pleased to offer our assistance in development of changes when the Committee considers the programs in greater detail.

95th Congress
2nd Session

Bill No. _____

IN THE (SENATE) (HOUSE) OF THE UNITED STATES

Date _____

_____ of _____ introduced the following bill;
which was read twice and referred

to the _____ Committee

A BILL

To provide for the immunization of children against major infectious diseases.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

FINDINGS AND DECLARATION OF PURPOSE

SECTION 1. The Congress finds that - -

1) Many communicable diseases are preventable through an adequate infant and childhood immunization program;

2) there is an increased incidence of some preventable diseases due to the declining rate of immunization of infants and children;

3) the states, in conjunction with private and public health services, are the most appropriate forum for administering a child immunization program;

4) any immunization program should be, insofar as practicable, a part of a preventive health care program carried out in conjunction with other health needs of the child; and

5) there should be no financial barrier to immunization of children.

Therefore, it is the purpose of this Act to assist the states to develop programs to immunize children against preventable infectious diseases.

SECTION 2. The Public Health Service Act is amended by adding the following new section:

"Sec. 316. (a) The Secretary shall, according to the schedule in subsection (b), pay to any state (which has enacted a mandatory child immunization program meeting the standards of subsection (c)) a portion of the costs of planning, implementing and administering such program. Such payments shall also include the costs of necessary vaccines, medications and other treatments.

"(b) The Federal share payable to any State that qualifies under subsection (a) shall be determined as follows:

"(i) for fiscal years 1979, 1980, and 1981, the Federal share shall be 100% of the costs of the program;

"(ii) for fiscal years 1982 and 1983, the Federal share shall be 75% of the costs of the program;

"(iii) for fiscal years 1984 and 1985, the Federal share shall be 50% of the costs of the program;

"(iv) for fiscal year 1986 and succeeding years, the Federal share shall be 25% of the costs of the program.

"(c) In order to qualify for Federal payment under this part, a State's mandatory child immunization program shall:

"(i) be so structured as to achieve and maintain an immunization rate of at least 90% against the diseases listed or to be determined by the Secretary as amenable to reduction, under subsection (c)(iii) for all children under age 18 in the State within two years of enactment of such State program;

"(ii) provide for necessary follow-up immunizations where medically indicated;

"(iii) provide immunizations against measles, rubella, poliomyelitis, diphtheria, pertussis, and tetanus and such other diseases as the Secretary, after consultation with national medical and public health organizations, may determine are amenable to reduction through a comprehensive immunization program;

"(iv) coordinate with, and utilize the services of, private health practitioners and facilities to the extent practicable;

"(v) make available immunizations for all children and assure that there shall be no financial barriers to receipt of such immunizations;

"(vi) provide that no child shall be forced to receive immunizations if that would contravene the child's, or the parents' or guardians' thereof, religious or moral beliefs; and

"(vii) provide for an accurate system of records of all immunizations administered under the program and for notification of an individual's personal physician of all immunizations administered by a party, agency or other entity other than the personal physician.

"(d) In the event that the Secretary, after consultation with national medical and public health organizations, determines under subsection (c)(iii) that another disease (or diseases) is (or are) amenable to reduction through a comprehensive immunization program, the Federal share of the state's expenses of an immunization program directed at such disease (or diseases) shall, for the first two fiscal years following such determination by the Secretary, be 100 percent. For fiscal years following the first two years, the Federal share shall be determined according to subsection (b).

"(e) There are authorized to be appropriated each year such sums as are necessary to implement the provisions of this section."

SECTION 4. Section 317 of the Public Health Service Act is amended by:

(a) deleting from subsection (b)(2) the sentence beginning "The Secretary shall give special consideration" and ending "private entities and volunteers.";

(b) by deleting from subsection (c)(3)(A) the phrase "(including vaccines and other prevention agents)";

(c) by deleting from the first sentence of subsection (f) the phrase beginning with "rubella, measles "through" diseases), and";

(d) by deleting from the second sentence of subsection (f) the words "vaccination programs,";

(e) by deleting subsection (g)(1)(A);

(f) by deleting from subsection (g)(1)(C) the words "or (B)"; and

(g) by renumbering paragraphs (B), (C) and (D) of subsection (g)(1) as "(A)", "(B)", and "(C)" respectively.

Senator HATHAWAY. That concludes the hearing, and the committee will recess until March 1.

[Whereupon, at 12:21 p.m., the hearings were adjourned, to reconvene on March 1, 1978.]

HEALTH SERVICES EXTENSION ACT OF 1978

WEDNESDAY, MARCH 1, 1978

U.S. SENATE,
SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH,
OF THE COMMITTEE ON HUMAN RESOURCES,
Washington, D.C.

The subcommittee met, pursuant to notice, at 9:35 a.m., in room 4232, Dirksen Senate Office Building, Senator Edward M. Kennedy (chairman of the subcommittee) presiding.

Present: Senators Kennedy, Javits, Pell, and Chafee.

Senator Kennedy. We will come to order.

I am pleased to open this hearing on health services programs and the way we deliver health care in the United States. Today's hearing will give us an opportunity to build on the record this subcommittee developed on these programs in field hearings last fall, and in a session last month during which the administration presented an outline of its proposals.

The subcommittee's earlier hearings examined in detail the Community and Migrant Health Center programs. We visited several of these centers last November. I believe that the record we have developed will enable us to send to the Senate a bill which will provide for the needed long-term stability and continued growth of these programs. They have clearly demonstrated their effectiveness in delivering, at a reasonable cost, comprehensive health services to urban and rural communities previously without health services and health care facilities.

Today we will focus on some of the other important programs which are part of the Federal Government's effort to strengthen health services delivery systems and to control and prevent special diseases.

Our first panel will discuss the critical state of maternal and child health service programs. Millions of children still lack the most basic health services. Federal programs created in 1912 are no longer responsive to the needs of today's society. Right now there are almost 20 different major Federal programs which finance or provide health services for children and expectant mothers—programs in HEW, the Agriculture Department, and Headstart—and they are not coordinated.

Our panel this morning will describe how the fragmentation and duplication of Federal health care initiatives has resulted in large gaps and the waste of scarce resources. It is my hope that their comments will help us establish the kind of bold and far-reaching changes necessary in Federal-State legislation concerning child health care.

We will also hear testimony on the extension of hypertension programs and grants for Public Health Services. Hypertension, for example, afflicts more than 23 million people. It is a major cause of strokes, which kill over 200,000 Americans each year and disable over 250,000 people under the age of 65. Our witnesses have extensive firsthand experience with these programs and I look forward to their comments on the adequacy of present funding and changes which may be required in these programs.

Our final panel will discuss the impact of genetic diseases and the effectiveness of HEW's programs to assure that the American people have available to them the latest information about genetic diseases, and the latest and most effective counseling and treatment services. Genetic disease is a major cause of disability and death in our population. It affects individuals of all ages, and its consequences are as tragic as any cause of ill health.

We owe it to parents, their children and their children's children to focus attention and resources on the devastating diseases which are genetic in origin.

The testimony we will hear today, together with information gathered in our earlier hearings, should provide us with a sound basis for a final bill which will strengthen and support programs to improve the delivery of health care services to those most in need.

I will ask the panel on maternal and child health to begin.

[The prepared statement of Senator Kennedy follows:]

PREPARED STATEMENT OF SENATOR EDWARD M. KENNEDY

I am pleased to open this second day of hearings on health services programs. Today's hearings will give us an opportunity to build on the record this subcommittee developed on these programs in field hearings last fall and in a session last month during which the administration presented an outline of its proposals.

The subcommittee's earlier hearings examined in particular detail the community health and migrant health center programs.

We visited several of these community health centers last November. At community health centers in Miami, Houston and Los Angeles I was impressed with their facilities and equipment, and with the very dedicated and hard-working people who staff the centers. We talked with many of the people who use the centers. Without exception, they felt that in the absence of this grant program, they would not have access to the kind of care which they have a right to expect. They felt their participation in the governance of the centers helped make the services responsive to their needs and desires. And they expressed to me their feelings that the support for the centers must continue and be expanded.

We also visited a migrant health center and a migrant camp in Homestead, Florida. The contrast between the modern facilities available through the community health center in Miami, and the old, crowded ill-equipped health facility used by the migrants was startling. The migrants told me they could use the modern facility in Miami, but preferred the migrant health center which was closer to their camp, and where the staff seemed more sensitive to their special needs and problems. The migrants made it very clear to me that they felt they needed the special migrant health program, and would oppose any consolidation of that program with the broader community health center program. They also pleaded for increased funding of the migrant health program and continued requirements for migrant control of the projects.

These programs were examined in further detail at the Subcommittee hearing here in Washington last month. I believe that the record we have developed will enable us to send to the Senate a bill which provides for long term stability and continued growth in these programs which have demonstrated

their effectiveness in delivering comprehensive health services to urban and rural communities previously without health professionals or health care facilities.

Today we will focus on some of the other important programs which are part of the federal government's effort to strengthen health services delivery systems available for underserved areas and populations, and for control and prevention of special disease.

Government programs for children were among the first health care efforts of the Federal Government. Over the last sixty-five years they have provided services to many children who would otherwise not have received needed care. Tragically, however, there remain some five to ten million children in the United States without any public or private sources of comprehensive and continuous health care. They seek and receive treatment services only in times of emergency, lacking access to primary health care that might have prevented these health crises. At the same time, the mothers of 10% of all newborns receive little or no prenatal care thereby increasing the risk of subsequent illness and disability to themselves and their infants. Not unexpectedly, the poor, persons in rural and inner city areas, and minorities are disproportionately represented in the maternal and infant mortality and morbidity data which reflect insufficiencies of the current health and medical care system.

Since the original Children's Bureau was created in 1912, the basic organizational and delivery components of maternal and child health care have not been significantly changed. The evolution of concepts in health care organization, financing, and delivery in this country makes it imperative that this basic health legislation and its administrative structure be examined carefully and modified to meet current and future considerations bearing on the health of mothers and children. Right now there are almost twenty different major federal programs which finance or provide health services for children and expectant mothers—programs in HEW, the Agriculture Department, and Head-start—and they are NOT coordinated. I believe that the time is now ripe for bold and far-reaching changes in the Federal/State legislation concerning child health care. A national effort orchestrated by strong, courageous, focused and creative leadership is desperately needed. There is no substitute for local and state participation in the planning and design of these services, BUT, unless federal encouragement, leadership, standard-setting and support accompany local efforts, unacceptable variability in emphasis and quality will continue to exist.

The Department of Health, Education and Welfare, the Children's Defense Fund, the American Academy of Pediatrics, the Carnegie Commission, the American Public Health Association, the American Parents Committee, and many others have called for an intensive review and change in the way services for mothers and infants are financed and delivered. A recent report of the American Academy of Pediatrics was extremely critical of present programs, citing the "fragmentation and duplication of Federal health care initiatives . . . result in gaps and waste of scarce resources." The report pointed out specific and extreme limitations in data collection, coordination of medical and social services, special services for teenagers, and research capacity. The Children's Defense Fund made a similar case in *Doctors and Dollars Are Not Enough*.

Today, I hope to begin this review. We have been working on alternative approaches that would make dramatic changes in the financing and delivery of maternal and child care, and would begin to focus the Federal effort in this area. I do not view this strategy as a substitute for a program of National Health Insurance, but rather as a process to initiate change immediately bridging the present with the future. I hope our first panel will shed some additional light on this important area.

Our second witness will focus on HEW's hypertension program. Hypertension afflicts more than 23,000,000 adults, or approximately 18 percent of the American population. It is a major cause of stroke, which kills over 200,000 Americans each year and which maims or disables over 250,000 below age 65. It is a major accelerating factor of arterioscleriosis, the process which causes heart attacks. It contributes to some 1,250,000 heart attacks and some 650,000 heart attack deaths a year.

National surveys show that the condition is more prevalent among blacks than whites and more prevalent among the older people than younger adults. For those aged 65 to 75, we estimate that 55 percent of the blacks and 39 percent of the whites have definite hypertension. Added together with those aged 75 and over, we estimate that about 8 to 9 million persons aged 65 or over have hypertension.

Presently, the assistance program to states provides some $11 million in formula grants to state health authorities for establishing and maintaining programs for the screening, detection, diagnosis, prevention and referral for treatment of hypertension. These funds also support public information and professional education, as well as evaluation of patients' needs and follow-up Awards are made on the basis of a formula which allocates $10,000 to each state and provides for distribution of the remainder based on a state's population and financial need weighed by the extent of the hypertension problem within the state. Although this program has only been in effect for the past two and a half years, it has provided a needed highlight and support to state efforts in this important prevention area. S. 2474 provides for a one-year extension of the authority for this program and provides for a fiscal 1979 authorization of $15 million. This time will allow us to evaluate the program and determine its place within the context of a new, comprehensive federal prevention initiative.

Our third panel will present testimony on Section 314(d) of the Public Health Service Act, which funds programs and systems for comprehensive public health services to states. Over the last ten years the program has provided flexible funding to support a variety of state public health programs. In recent years the program has operated at a level of $90 million which has been divided among the states on the basis of their population. S. 2474 provides a one-year extension to allow us to evaluate and review the program within the context of new federal health program initiatives. S. 2474 also provides an increase in the funds authorized under 314(d) to provide added support to state public health programs.

Although 314(d) programs have suffered from a poor reporting system, its basic flexibility allows for an important creative use of the federal funds in line with local needs. The Subcommittee hopes to solicit constructive comments concerning its operation and value, and will take these comments into account in considering effective ways to support state public health efforts.

We will also be hearing today a series of witnesses discussing the Genetic Diseases Amendments of 1978, S. 2597. This legislation amends and reauthorizes the National Sickle Cell Anemia, Cooley's Anemia, Tay Sachs and Genetic Diseases Act.

This important piece of legislation supports programs aimed at ensuring that the American people have available to them the latest information about genetic disease, and the latest and most effective counselling and treatment services for those conditions. Unfortunately though it was passed three years ago, it has never been funded until this year, and then, only at the meagre level of 4 million dollars.

This failure to support more adequately these critical services is a tragic oversight on the part of our federal authorities. Genetic disease is one of the major hidden causes of death and disability among our population. It is the second leading cause of death below the age of one year. Seven out of every thousand newborns have some chromosomal abnormality which impairs their health. And adults can be affected in the most devastating fashion, as some of our witnesses can attest from tragic personal experience.

I want to commend Senator Javits for the fine work he has done in drafting S. 2597. It extends the Genetic Disease authorities for three years at the modest authorization level of 30 million dollars. The bill also adds some helpful perfecting modifications to the law. It will make clear that the Congress intends funds allocated under these authorities to be available for research and services applicable to all genetic maladies, not just those listed in law by name for the purposes of illustration. S. 2597 also spells out Congress' intent that screening programs funded under the Act should also provide for referral for treatment of any disorders detected.

Senator KENNEDY. We are fortunate to have Lisbeth Bamberger Schorr from the Children's Defense Fund, a personal friend and

long-time friend of this committee. She has written about these issues for many years and has been a great source of help to all of us.

Also on the panel is Dr. Donald A. Cornely, American Academy of Pediatrics, Johns Hopkins University Community Pediatric Section, Baltimore, Md. and C. Arden Miller, Professor and Chairman of the Department of Maternal and Child Health, University of North Carolina, Chapel Hill, North Carolina, who is also a student of this particular issue.

We look forward to their testimony.

STATEMENT OF LISBETH BAMBERGER SCHORR, CONSULTANT, CHILDREN'S DEFENSE FUND, WASHINGTON, D.C., ACCOMPANIED BY DONALD A. CORNELY, M.D., AMERICAN ACADEMY OF PEDIATRICS, JOHNS HOPKINS UNIVERSITY COMMUNITY PEDIATRIC SECTION, BALTIMORE, MD., AND C. ARDEN MILLER, PROFESSOR AND CHAIRMAN OF THE DEPARTMENT OF MATERNAL AND CHILD HEALTH, UNIVERSITY OF NORTH CAROLINA, CHAPEL HILL, N.C., A PANEL

Ms. SCHORR. On behalf of the Children's Defense Fund, we very much appreciate this opportunity to talk to you about today's major unmet health needs in maternal and child health and what should be done to meet them.

We are, of course, familiar with your longstanding concern with improving the health of all Americans, especially those who have not been well served by the health system in the past.

Your extension of this concern to the special needs of children and mothers, and to the special opportunities to improve the health services available to this population comes at a critical time. The enormous increases in health care costs have concentrated public and governmental attention on ways of cutting costs—which are indeed exorbitant; on eliminating excess services and equipment—many of which indeed do more harm than good; and on controlling the number of specialists—who are indeed responsible for ordering many unnecessary and expensive procedures. Concerned as we are about excesses in the high technology part of our health system, we tend to lose sight of its stark deficiencies in delivering simple primary care—the many Americans virtually excluded from all but emergency care, the millions who lack access to the care they need.

There is a great gap between the demonstrably effective interventions in our health services armamentarium, and the services our health system actually delivers. Nowhere is the gap more striking than in the care of infants, children, adolescents, and pregnant women—especially those who are part of disadvantaged populations. These are the groups for whom primary care and especially preventive services are most important. But our failure to reach all American children and mothers with effective primary care is abysmal.

Twenty million children, 39 percent of the total, under age 15 are not properly immunized against one or more of the six potentially dangerous childhood diseases for which vaccines are available. The number of unimmunized children goes up sharply as income

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goes down. And we know two things about unimmunized children. We know they are in danger of serious illness and disability. And from the fact that they are not immunized, we know that they are not receiving regular health supervision, which every infant and child urgently needs to promote health development.

There are half a million children who suffer today from hearing loss—a major factor in learning problems. Half of these cases could have been prevented by proper diagnosis and treatment of middle-ear infections.

Between 65 and 85 percent of acute rheumatic fever that occurs each year could be prevented with proper detection and treatment of strep throats.

About one-half of the 3.7 million 15- to 19-year-olds at risk of unintended pregnancy are not receiving family planning services. Improved availability of family planning services to women of all ages would prevent a high proportion of births of unwanted children, an unknown number of abortions, and large numbers of births of children at a time when health risks and the risks of damaging social and economic consequences are extremely high.

Pregnant women at the highest risk get the least medical attention; 7 out of 10 mothers under 15 get no prenatal care in the first trimester, one-fourth get no prenatal care at all, or delay it until the end of pregnancy; almost twice as many black as white women get no prenatal care, or care only in the last trimester. Late and inadequate prenatal care is, of course, closely linked with infant mortality, birth defects, mental retardation, and subsequent developmental difficulties.

What keeps us from closing the gaps between promise and performance of our health system?

Reducing the economic barriers by expanding third-party payments through public and private financing plans is only part of the answer. A universal national health insurance program is essential.

Compared to complexities of the rest of the health system, what is needed to make major improvements in maternal and child health is relatively simple. Why traditional maternal and child health programs have not achieved their potential is a matter that particularly needs attention.

In the executive branch and both Houses of Congress, there is leadership already committed to giving high priority to effective action to meet the health needs of mothers and children. What is it that needs to be done?

1. We need to be sure this full range of appropriate health services are available to mothers and children.

Bureaucratic or other barriers which isolate curative from preventive services, which keep doctors from collaborating with social workers, which send pregnant women to one place for physical examinations and to another for help with nutritional needs are surely, in 1978, like the walls of Jericho, ready for action to make them come tumbling down.

We know by now, for sure, that for an effective response to most of the needs that children and mothers bring to the health system, we require both modern medical interventions and quite simple

services—services that entail teaching, listening, counseling, the mobilization of social supports, and even social action. We know by now, for sure, that the separation of certain services traditionally delivered in the private sector from others relegated to the public sector, has not worked and will not work.

However, the sources of funds are segregated or integrated in legislation, the services they pay for cannot be allowed to come in incoherent bits and pieces at the point of delivery.

The brunt of fragmented care, of course, falls disproportionately on the poor. It is the poor who typically have to negotiate the maze of multiple offices, confusing and conflicting eligibility requirements, bus trips, waits, and missing records. They are the most frequent victims of the lack of coherent policies, of the inability to reconcile the requirements of categorical funding authorities, or governmental reluctance to use the leverage of its funds to encourage needed changes in service delivery.

But today there is widespread recognition—and impressive evidence—that most primary health services are best provided by or through a single easily accessible port of entry. The availability of comprehensive continuing care in one place has been shown to be highly effective in improving health and family well-being as well as in controlling health costs.

Families tend to use providers who can respond to health needs the family considers important. Providing a full range of health services under integrated auspices seems to be more effective than complicated computerized case management systems—coordinating a host of disparate services—to make sure mothers and children get the health care they need when they need it. The accumulated evidence is impressive. Especially among the population groups that are most important to reach, primary care for mothers and children is most effectively rendered when there is access through one door to medical, educational, counseling, mental health, nutritional, and social services.

There are, of course, services that are most effectively made available in settings outside the curative care system, and individuals who are more easily reached in nonmedical settings. There is considerable evidence of the success of separate organized family planning programs, and of the use of schools and health departments for immunization campaigns. There is evidence of effective use of multipurpose teen centers to provide health care to adolescents; of schools to provide preventive dental services and vision and hearing screening.

A promising program is underway under the auspices of the R. W. Johnson Foundation to train and employ nurse-practitioners to provide and coordinate certain primary health services in a school setting.

There is no good a priori formula to identify appropriate settings and contexts for the provision of needed services. For example, screening of developmental difficulties and immunizations are frequently seen as services that are most cost-effectively delivered through the schools. But what about the importance of these services for preschool children? Detection of developmental lags at school entry may not be soon enough; immunization rates among preschool

children are considerably below those of school children. Since frequent and continuing contact with the health system is probably most important in the early years, these examples suggest that it may be appropriate to emphasize different settings for different services at various stages of life.

It would be nice to think that these decisions could be made in each community. But the way the Federal Government writes its laws and regulations for payments under medicaid, its direct grant programs, its formula grant programs, and its benefits package under national health insurance are powerful determinants of who will be able to get what services where. For this reason, we need an extremely careful sorting out of these issues, so that resources can be allocated in some rational relation to their effective use, rather than in response to tired rhetoric, bureaucratic rigidities, or the pressures of a panoply of vested interests.

2. We need more organized settings to make needed services more widely available, accessible and acceptable.

It is now well recognized that simply making money available to reimburse providers through health insurance or medicaid—even for a broad range of services—does not assure that the appropriate professionals will be available, or that they will be within reasonable reach, or that they will offer services in circumstances that are humane and make sense to the users of care. Appropriate health services will be more widely available and better utilized as more organized settings are established, where a variety of personnel can work together, and where strong ties can be forged between the providers and the people they aim to reach.

The kinds of organizational arrangements that will make appropriate and high quality primary care accessible to most people not now well served by the health system do not, with stellar exceptions, now exist. They will have to be created. There is ample experience to build on in the successful operation of neighborhood and community health centers, children and youth centers, maternal and infant care projects and some health maintenance organizations.

Individual practitioners and other providers offering limited services should be able to obtain help in making connections with other sources of needed services. It is also important to encourage the development of small low-technology primary care centers, which could be attached to community programs, such as day care centers, and which emphasize easy physical and psychological access.

A major Federal commitment is needed to assist professionals and consumer groups in local communities to establish and operate these organized settings and organizational links. Specifically this means:

A. Technical assistance and start-up funds for provider groups serving underserved areas.

B. Subsidies for health-related support services and for services designed to make health care accessible to people in underserved areas and to groups with special needs.

C. Encouraging the adoption of payment methods—including provisions to facilitate annual per capita payments and other alternatives to fee-for-service—which are simple to administer and which

provide incentives for using the most appropriate services and personnel.

D. Suitable standards and methods of certifying providers and organizations, administered in ways that do not discriminate against any class of qualified providers or provider groups—be they physician assistants, nurse-midwives or neighborhood health centers.

3. We need to encourage the development of and provide support for effective ways of linking children and mothers to sources of comprehensive health care.

Effective and economical utilization of health services, especially by mothers and children, and especially by disadvantaged populations, require good outreach programs and other ways of easing access.

Even when financial barriers are removed, the remaining barriers to access are more likely to keep poor people away from preventive services and other important primary care than from care for severe illness. Discrepancies in the health care received by the poor and the rest of the population are most striking in the use of preventive care. Poor people, especially poor children, use substantially less preventive services than the nonpoor, even when the poor are covered by a relatively comprehensive medicaid program.

This means that subsidies must be available to qualified providers—including primary care centers, community clinics, group practices, HMO's, hospital outpatient departments, and health departments—serving areas with large numbers of persons who have not had good access to the health system in the past, to assist them in providing services which have been shown to be effective in getting people to primary health services. Not every measure labeled "outreach" will do. Written notices alone are virtually useless. Personal outreach performed by trusted community members, and other support services, like transportation, must be made available to all population groups that lack ready access to continuing primary health care.

We have comparatively little experience in this country with the practice of combining outreach with provision of services valued by recipients. The experience we do have makes clear that home visiting by trained health workers, especially to families with newborn infants, and other kinds of services offered in the community are among the outreach arrangements that deserve to be further developed and evaluated.

4. We must develop and support ways of establishing reasonable standards of care and assuring they are met for all mothers and children.

One of the most vivid lessons to emerge from the children's defense fund's study of the early and periodic screening, diagnosis and treatment program, was that minimum standards of quality are not met unless they are clearly stated, monitored and enforced. Children who were screened through EPSDT often received incomplete health assessments. Even States with good administrators, relatively prosperous economies, and reasonable amounts of resources did not necessarily assure high-quality services. Both the Institute of Medicine study by David Kessner—Assessment of Medical Care for Children, 1974—and the Harvard Child Health Project Report, 1977, have

documented in great detail the poor quality of much of the health care that children routinely receive.

5. We must find better ways to establish standards of care, especially in those areas of practice where optimal procedures are widely agreed upon within the medical profession, and to make information about such standards more widely known.

The proposal that you, Senator Kennedy, have made for an expanded Federal commitment to health care research would, we believe, be extremely helpful in attempts to identify more systematically effective procedures and the organizational and manpower factors which affect the quality of services. As the Harvard child health project pointed out, more research efforts should focus on improving capacities to recognize, diagnose, and treat childhood illnesses, and more research on delivery and financing alternatives needs to be directed toward children's primary care, if the health system is to become more effective in responding to the special needs of children.

On the basis of what we know now, however, we can proceed with a reasonable degree of certainty that quality will improve with the greater availability of a broad range of services, the further encouragement of organized settings and the monitoring and enforcement of accepted standards of care.

In addition, ways must be developed through which the health system can assume responsibility not only for those who come through the door seeking care, but also for those who fail to enter the system. Some existing programs, including HMO's and community health centers, have demonstrated the feasibility of assuming responsibility for a defined population—defined either through enrollment or place of residence. Such a defined population makes possible monitoring and assessments of performance which can have an enormous positive impact on quality of care. This concept must, however, be expanded beyond isolated groups of persons who are linked to a certain provider or group of providers. It is only when mechanisms are developed through which everyone becomes part of a defined population, for purposes of planning and accountability—if not for purposes of delivering services—that we will be able to assure that required health services are available and accessible for the entire population. It must be possible, in any given area, to identify who is responsible for providing a given set of services and who, therefore, is responsible if the services are ineffective or unavailable.

Whether one single mechanism can be found to accomplish this task in each community throughout the country is, in our view, still unclear. There is currently considerable controversy over the issue of whether health departments, at both the State and local levels, could mobilize the kind of talent that the task requires, and the kind of commitment to the interests of consumers of care that would make them credible as the agencies to which consumers could turn for assurance of accountability. We may need to begin by using a variety of arrangements.

The relationship between official health agencies, planning agencies, a potential maternal and child health authority and the providers of maternal and child care will be intricate and complex and must be carefully designed.

What should be clear from the outset, however, is (1) that the accountability function should cover all mothers and children, regardless of their source of care or source of payment for care, and (2) that the Federal Government must be in a position to respond to evidence from any locality that the designated agency or organization may not be suited to perform the accountability of function, to assure that the accountability function is being exercised in the interests of the consumers of care, and to replace any agency not performing its function effectively.

6. We need to make sure consumers can effectively participate in the formulation of policy and resource allocation at all levels in the delivery of maternal and child health services.

Such participation should occur through a variety of mechanisms, some of which remain to be developed, and would cover a wide spectrum, from improved information to equip consumers to participate in and monitor their own and their children's care, to consumer participation in the operation of organized health delivery programs and health planning agencies.

Consumer participation is essential if health policy is to take into account the realities of how people actually use health care. Health care must be organized to respond to family needs in ways that make sense to families and that support family function. Parents must be given the opportunity, the information, and the support to function as collaborators with health professionals in maintaining and restoring health.

We need to be certain that there is a strong Federal leadership role in setting and enforcing standards for performance and for the allocation of resources.

Whatever methods and whatever funds are used to finance needed maternal and child health services, and to develop and support the infrastructure to deliver the services and to assure their continuing quality and receipt, the Federal Government must assume ultimate and residual responsibility. There must be a data system designed to generate and make available the information needed to monitor and evaluate all maternal and child health activities undertaken with public support. There must be a strong central review capability to provide the basis for a coherent national policy and for effective local monitoring.

The Federal Government, if it delegates to States the responsibility to assure that required health resources are available and accessible, must be in a position to know how and for what purposes funds are being spent, must have the information to judge whether a State's plans and practices conform with clearly defined standards and purposes, and must have the authority to assure that the intent of Congress is actually carried out.

The issues I have dealt with in this testimony are made vivid in the story of a Mississippi child, told in last Sunday's Washington Post. She died last June at the age of 5, of secondary pneumonia, brought about by a bacterial infection caused by Ascaris worms in her intestines. After her death, the community health center in Jackson—65 miles away—sent people out to build a privy and install a 55-gallon barrel of water. For the first time, the family had clean

drinking water. The health center helped get the surviving children on the WIC program and helped comfort the grieving mother. But the next time the center's social worker went to visit the family, no one could be found. The mother was in jail for child neglect, and the children had been put in foster care. Dr. Aaron Shirley, director of the center, and a pediatrician who fights each day for Mississippi children against the most overwhelming kinds of odds, says that the neglect was not the mother's, but ours. He explains that the symptoms of Ascaris worms, which may look like a cold and runny nose, simply are not those that would signal the need for an emergency trip to the hospital. Hence, the necessity of outreach, the importance of easy access to a source of regular care.

I talked to Dr. Shirley earlier this week, and he said that little girl's death was not an isolated instance. And the nonsupportive punitive response of the welfare agency is also typical. Dr. Shirley was asked by the Post reporter if things were not getting better though.

"Sure," he says,

> The ones who know enough to come to a clinic are better off now than they were before medicaid * * * Sure, you're better off if you can fight the hassle and pay for food stamps. But Heaven help you if you don't know what to do. For those kinds, there is just no one reaching out. There is just no caring.

Perhaps this committee will keep this story in mind as you address the issues of Federal action to improve maternal and child health, as you look afresh at what administrative and organizational arrangements will succeed in mobilizing the resources of Government at all levels, professionals of all skills and consumers in every segment of the Nation—to the end that mothers and children will receive the health services they need. The danger is greater chaos and more and more money for less and less adequate and appropriate services. The task is to harness an increasingly complex health system to simple human needs—and no longer to permit these needs to be subordinated to the vagaries of the system.

Thank you.

Senator KENNEDY. Excellent testimony. We are going to run into a problem all morning because of the objection to committees meeting during the Panama Canal debate. We will submit questions. I would like to just ask a couple of questions though. One deals with just your characterization of the Federal leadership role in setting and in enforcing standards for performance in allocation of resources.

You mentioned obviously the importance of data collection system, which I completely agree with. We are not doing nearly enough in terms of that in terms of a general health mechanism.

What can you just tell us about your assessment of that particular responsibility at the present time?

Ms. SCHORR. On the existing maternal and child health services that are funded through formula grants to the States, it is very, very hard to find out what is actually going on. We do know that State plans are prepared. They are logged into a regional office. They are checked off, and the question of whether there is language in the plan covering various components is checked off. But that is where the

Federal supervision ends. There is no judgment made on the substance or adequacy of the State plan.

The fact is that no judgment can be made because there is no basis for making the judgment. There is no independent data base, which a Federal administrator can use to compare with what the State sends in. There are no quality standards. There is no body of knowledge to which the plan can be compared. The result is no Federal supervision, and a complete awareness out in the field that there is no Federal supervision and can be no Federal supervision under existing circumstances.

Senator KENNEDY. Well, that is certainly our impression, too, one of real chaos. It is a really classic failure. You touched on something earlier and we will hear some different views on this about the State role today. I think you have given a pretty candid view in regard to the Federal role—what about States themselves, after they make whatever applications they do, they run through the routine of this, what has been their kind of performance?

Has this been primarily a slush fund used for a variety of different purposes or could you identify perhaps some of the places where it has been worthwhile and give whatever generalization you would?

Ms. SCHORR. Senator, we at Children's Defense Fund found it was extremely hard to find out what was actually happening with maternal and child health money that went to the States except for the money that went as project grants for children and youth centers and maternal and infant care centers, where we have quite dramatic evidence of the very, very effective use of the money.

Now, some of those are being continued at least to some extent under the formula grant program. But what is actually happening with the rest of the maternal and child health money, we cannot make any better judgment than the Federal Government can because we cannot find out to what purposes that money is going.

Senator KENNEDY. Your point is that we ought to establish some accountability, some clear criteria, in terms of what we expect from the money that will be provided in the States and then some monitoring as to whether these criteria actually are going to be followed?

Ms. SCHORR. Some very explicit monitoring, and then some authority to be able to assure that the purposes of the congressional intent are actually being carried out at the local level.

Senator KENNEDY. How about EPSDT program? What improvements would you make in that?

Ms. SCHORR. The EPSDT program has done a very useful thing. It has made additional Federal funds available for health services, for primary health care for children. It has all the limitations of the program under which it operates, medicaid. Medicaid is basically a financing program which does not get at the issue of resources, and has not in the past gotten at the issue of the structure in which it operates. The present legislative proposals, however, to improve EPSDT would get at some of those issues, and we believe would result in some of those funds being more effectively spent.

Senator KENNEDY. We have some other questions, but I want to try to hear the others on the panel.

Professor Miller.

Dr. MILLER. Senator Kennedy, thank you for the privilege of meeting to discuss the maternal and child health population and programs. I have not prepared testimony in printed form in advance.

I would like to address my comments around three principal issues.

One, what characterizes the MCH population in terms of special attentions it deserves? I will not dwell on expanding the excellent documentation Ms. Schorr has already provided on the neglect to the health of this population.

Second, I would like to emphasize some principles for considering revision of present policies and programs in support of health services to the MCH population.

Finally, I would like to suggest some specific actions that may be indicated.

The characteristics of the population need to be kept paramount—women of childbearing age, infants, children, and youth of this country represent by far our most vulnerable and neglected population group. They deserve and require special finance and special programs for their needs.

The evidence is abundant that when they are folded into finance and programs that are intended to serve the entire population, without special priorities being attached to them, that these vulnerable people get pushed to the end of the line. I think it is necessary that special attention focus on them.

Another characteristic of the Maternal and Child population is derives from their special programmatic requirements. Because they require special emphasis if their needs are to be met, there is unique public responsibility on their behalf.

Forty years ago, with enactment of the Social Security Act, it was established beyond doubt that our conventional system of health service could not succeed in reaching all women and children in an equitable fashion. It was established that there is a unique public responsibility to provide services that will reach them. That finding is no less true today than it was 40 years ago. There is a unique public responsibility to provide services to women, infants and children.

Principles to be borne in mind as we contemplate revising the maternal and child health authorization and funding include: No. 1. The purpose of these programs must be to serve a population, not to serve a professional group, not to serve a special reimbursement or payment device, not to serve special interest groups.

No. 2. Expectations of the program must be defined.

We need to specify what services are required, we need to establish standards for performance and achievement. It will not do any longer to pump money into health service programs in the expectation that something good will come of it. We need to define what that something good is to be. I think the country has made progress in recent years and even recent months in defining health goals. We have done this around a defined infant mortality rate that represents a national goal. We have done it in defining acceptable immunization rates. I think it would be possible to define outcomes and goals in many other areas relating to maternal and child health.

No. 3. As these service requirements and expectations are defined, I submit it is necessary to incorporate as part of the policy of ma-

ternal and child health an affirmative action complement on behalf of persistently neglected population groups.

We have seen within the past years a decline, for example, in infant mortality rate, but the rate of that decline is much better for white populations than it is for black. The gap between ethnic groups, not only as measured by infant mortality rates, but by immunizations and other indicators, continues to be distressingly large, not only between black and white populations, but between poor and more affluent groups. I see no way for the gap to be closed without explicit policy of affirmative action on behalf of neglected populations.

No. 4. It is important in maternal and child health to put in place service delivery systems that assure reaching all eligible people in the population. I support Ms. Schorr's emphasis on involving them in comprehensive services. But, in all candor, I am less concerned at this moment with the idealized nature of those comprehensive services than I am that everybody be involved in receiving something. The evidence is very good, both in this country and in developing countries, that service systems that are put in place, that reach everyone with some basic service, produce impressive results, and produce opportunity for expanding those services in future years. I think that ubiquity of care is important for maternal and child health populations. It requires, however, that more complete and comprehensive care be invoked for selected populations on a basis of affirmative action.

How do we do all of this?

There is much talk of a special emphasis on behalf of maternal and child health populations under national health insurance. I applaud that emphasis. There is discussion as well about revision of what is the very foundation of maternal and child health services in this country, title V of the Social Security Act. I happen to believe that no matter what is done under the banners of the national health program, we need to preserve something like title V. It is the best device we have put in place so far for improving and expanding resources to serve maternal and child health populations. We could do worse than to maintain the wording of title V component of the Social Security Act as it is now.

The mandate and rhetoric of that act, address current problems. Why have those problems persisted for 40 years in the face of that reassuring legislation?

The failing is not bad legislation, but weak guidelines, inadequate standards, and an inordinate amount of State discretion on how the act is to be implemented.

Title V formula funds, as was intimated previously, are widely regarded as discretionary funds attached to optional programs. I think Federal standards must be established for performance of the title V programs, and Federal funds must be used explicitly to reach the defined populations in achievement of those standards.

I believe further that any revision of title V must be addressed specifically towards revising, protecting, expanding and improving services delivery capacity of State and local health departments. Those departments now reach one out of four Americans with some direct personal health services. It represents the only delivery system in this country by which we can assure that a population will be reached by essential services. Our private and voluntary delivery

systems, as important as they are and as important as they will continue to be, I think will continue to resist a regulatory emphasis which might assure their reaching everyone in an equitable fashion. We simply do not have regulatory models in our society to apply against private and voluntary systems to achieve equity in services. I think goal requires a public system of care on behalf of the maternal and child health population.

A special word need be said in relation to the comprehensive community-based programs of care, such as maternal and infant care and children and youth projects. They represent superb models that need be expanded on behalf of neglected populations. A lot of attention focuses on whether those programs are best left with the States where they have been put in recent years, or whether they should be returned to Federal authority. I am one who believes that these alternatives may not make a great deal of difference. I would be more reassured about returning them to Federal authority if those comprehensive community-based health service programs that have been retained under Federal authority had received better support within recent years.

All comprehensive community-based health service programs, whether administered under State or Federal authority, have been underfunded and neglected.

Those programs need to be expanded.

I would tend, myself, to keep them under State authority with the proviso that those States failing to meet obligations on behalf of neglected populations would be subjected to Federal takeover of the neglected programs, that there would then be Federal responsibility to reach the unserved populations, and there would be a Federal provision to withhold general revenue sharing funds from those States in order to provide the State's matching portion for those services. I believe that this expectation was implicit when many of the Federal health care programs were placed under State authority and when the revenue sharing funds were established.

I think we know how to do a vastly better job in reaching this entire population than has yet been done. They need special funding, special services, and high priority; I am delighted you are addressing yourselves to these issues.

Senator KENNEDY. The problem is, that is all well and good, but specifically what can you tell us what you think, given the existing legislation, or what changes would you make or what steps should be done in terms of the Federal Government to get full impact of this type of effort? Specifically what should be done? What should be done given the current status of title V? What would you like to see done?

Dr. MILLER. I would like to see established Federal goals for what title V should achieve—national performance standards. I would like to see those standards applied and enforced with States who accept formula grants, and I would like a firmly established Federal mandate for affirmative action to reach population groups who are not served by those standards.

Senator KENNEDY. Are you satisfied that under existing legislation that the authorities there could do all of that?

Dr. MILLER. I do not regard myself enough of an expert on legislation to respond to that. But I do feel strongly that the existing legislation enables vastly more than the Federal Government has taken advantage of.

Senator KENNEDY. In terms of the same question I asked Ms. Schorr, let me ask about your characterization of the State performance today.

What would you tell us about that?

Dr. MILLER. Uneven, known to be dismal in many respects, but I believe far better than is sometimes given credit for. Good enough not to be written off. Within recent years, this country has engaged in elaborate description of new models for delivery of health services and primary care. None of that attention has been addressed to excellent models that exist in the public sector of care in local and State health departments.

Senator KENNEDY. Dr. Cornely.

Dr. CORNELY. If I may have my prepared statement in the record.

Senator KENNEDY. Your statement will be inserted in the record at the conclusion of your testimony.

Dr. CORNELY. The American Academy of Pediatrics welcomes the opportunity to comment on public responsibility for health services for mothers and children. I would like to call to the committee's attention a few points.

One is that Congress has, through several mandates, made it clear that it has a commitment to the health of mothers and children, and simply by citing four different pieces of legislative history, it might be illustrative at least that Congress has indeed made that commitment.

It would be improper to ignore the initial piece of such legislation, the Children's Bureau in 1912, which was admirably broad in speaking to child health and its interrelationship with child welfare.

Next, as has been mentioned already, was the passage of the Social Security Act of 1935 and inclusion in it as one of its original titles provisions for maternal and child health. The third piece of legislation is the institution in 1963 of the National Institute of Child Health and Human Development which acknowledged a long-term obligation to pursue fundamental biological and social relationships, a necessity if we are going to be able to deliver what is promised.

I think the fourth piece of legislation which illustrates this is the passage in 1965 of the Medicaid Act with its later amendment for EPSDT.

One takes these four as more or less milestones and adds to them many separate pieces of legislation which were addressed to categorical diseases or issues, and one at least, I think, sees within limits that the Congress has committed itself, however fragmented and timid that commitment might be.

One moves then to administration and looks at HEW's implementation of these programs. Some of the fragmentation and inadequacies that one worries about as programs come out of Congress become realities. I would ask Congress to think when was the last time it ever had the Director of the Maternal and Child Health program

appear before any of its committees? I think you would find it is over 5 years ago.

Also, if you would look at where the major office bearing the name of Maternal Child Health is sequestered in HEW, you would find it about four layers below the Assistant Secretary of Health.

Another reality is that if you look at HEW in its 25-year history, it has had about 12 Secretaries. There is an itinerant nature to that office. I think if that is reality, for the Academy of Pediatrics one of the strongest things Congress could consider would be to add some structural base in HEW at the appropriate level, competently staffed and addressed to the health of mothers and children. If you do not do that, it seems to us that you increase the likelihood of the fragmentation which comes out of Congress and the inadequacies and misunderstandings which are associated with a parade of administrative changes about every 2 years. The present HEW occupation with reorganization results in less progress than one can tolerate very long.

Second, I think Congress should also consider when it passes legislation in which children's or mothers' health is a principal or primary focus, the possibility of administratively recommending, if not assigning, the responsibility for that legislation to a specific office of Maternal and Child Health. As it is now, you have maternal and child health programs, such as immunization, run by, for example, CDC. The primary population which is the target of immunization is children. You have an investigative agency in CDC attempting to administer a health program, thereby fragmenting the system. Congress must insist in some fashion when it passes a piece of legislation that it be placed in an appropriate office.

Well, the Academy has looked at two specific pieces of maternal and child health legislation recently, and, continuing the discussion, I would want you to know that we obviously have addressed these to the Senate Finance Committee which has current authority over these, so we will not be misunderstood.

The title V program, we find, is misunderstood—misunderstood by Congress and misunderstood by the administration—and it becomes the epitome of misunderstanding when you go down to the State level. Contrast for a minute the fact that in title V, Congress passes appropriations of about $400 million a year with the fact that in title XIX for children, as best as we can tell, the county spends between $3 and $4 billion a year. It should be obvious just from the difference in those comparative funds that it was never the intent for title V to be a major program that delivered health services even to the poor population in this country.

The purpose of title V was to identify distinct administrative units technically competent to address the many issues that are necessary in bringing a level of health to the mother and child population. From time to time, those units are given responsibilities to initiate more or less special projects—demonstrations to explore new relationships, for example, with crippled children. Even so, the approximately $400 million which Congress appropriates, matched by an equal amount from States, still only constitutes less than $1 billion a year to which that act addresses itself. We think if you read the

mandate, if you looked at the appropriation, you would see it was never the intent to do that under title V. But title V does bestow responsibility which we do not think has been fulfilled. It gives responsibility to develop resources. It gives responsibility to promote and implement standards. It gives responsibility to fact-find and to assemble information to stimulate programs of delivery.

It has not been doing that throughout the country in any way that could be considered satisfactory. Part of that is because of misunderstanding which starts at Congress, is aggravated as it goes through the administration, and becomes, as I say, almost abject confusion at the State level.

May I emphasize one other thing which has been said by both of my colleagues here.

Consider for a moment the major issue with which Congress and the Department of HEW have been diligently struggling in areas of health. You will get some idea how badly children do and mothers do in general health. You are talking about cost containment, control of fraud in medical care programs, and national health insurers.

Cost containment, control of fraud in medical care programs, and national health insurance are not issues prompted by a major concern for child health. Cost containment isolates short-term hospitalization and nursing homes, and these are not major components of a maternal and child health program, however important they may be to the broader health program.

Children frequent the inpatient side of hospitals very infrequently and have the lowest rate of hospitalization and the fewest days of hospitalization of any age group, and the differences are of great magnitude. Fraudulent use of public funds for health care can hardly be presented as a major problem in maternal and child health, since health services to these population segments are essentially of a preventive and ambulatory orientation. We do not experience an overuse of preventive health services for women surrounding maternity care or family planning services, and for children and youth. Quite the contrary, our struggle has been and remains to attempt to have children and mothers-to-be utilize even minimum services.

Members of this subcommittee know very well that if the costs involved in considering national health insurance were those projected for the maternal and child population needs, there would be little hesistancy in moving aggressively forward with a universal entitlement. But, children and their health needs tend to get lost in the complex of large expenditures and services required to serve the general—older age groups—population. Unless Congress takes the step to add a significant and appropriate structural base for maternal and child health in our Federal health administration, the Academy feels we as a nation simply fail to understand and meet our responsibility to children.

So, in HEW with a parade of Secretaries and with chronic reorganization, and with the acknowledged necessity to concern themselves with large expenditures, maternal and child health over time has simply moved to the end of the line.

We think one structural thing that Congress would be wise to consider doing would be to develop what you did in 1912, a deliberate

office, assign it in HEW at sufficiently high level, give it competent staff, and require it to carry out its obligation to States and State plans.

Second, when it comes to State plans surrounding title V, are think you would be wise to consider requiring that there be an advisory committee in each State to participate in the development of provisions for the enforcement of the State plan which the State must submit in order to get its formula grants. Without that, and without standards coming out of the national office, you are getting nothing but Pablum. What you are doing is having money coming out and being spent in such a fashion that you cannot identify any kind of technical competence in delivering services.

Last, you should pay some attention to some of the reorganization which further fragments the system at the regional office level. There was a deliberate attempt, successfully executed by administrations in the late 1960s, to decentralize the administration of programs in an acknowledged attempt to bring them closer to the people. This was a farce, however, since history has revealed that "decentralization" was simply a bureaucratic runaround.

The net effect is that regional offices are now stripped of any kind of technical competence to provide assistance to States of any kind of technical knowledge to implement national standards which should be required if you are going to be having effective State grant-in-aid programs.

Thank you.

Senator KENNEDY. We are interested in your proposal, the study that was done. We will make this a part of this record. I think it has a lot of material in it. It is useful. There are some common areas in both the approach you have outlined and outlined there, and one that I favor.

I just have one question. How are we going to get the private sector, the private physicians, the pediatricians really into this program, given the track record, given what the fact of the matter is in terms of the States at the present time?

Just in terms of my own State of Massachusetts, it is a very difficult time to get that kind of service to needy people and to the poor people. The question is whether just adding resources and adding money to the system is going to do very much. If you can comment upon what you have seen in recent times, what you think presently and where you think in the future how we are going to deal with that particular issue?

Dr. CORNELY. It is comfortable to represent pediatricians because they are the least difficult group to get involved with public responsibilities in public health programs. I call your attention to the fact that when the Academy of Pediatrics was formed, it was formed because it objected to AMA at that time refusing to support Federal-State grant-in-aid, and it formed itself to support that concept.

I think the major problem for the pediatricians who are in private practice, and I am not in that area, is the prohibitive confusion in Federal regulations. You see, Senator, they do not read the Federal Register as daily reading matter. The next thing you know, before they get around to knowing there is a proposal to be put out by the

Department, they are already enforced. This results in complexities and confusion.

Then they are justified on the basis that the administration has to have accountability. That is a true statement, but that is not justification for complexities. Most of the time pediatricians whom I know from working on that particular task force on title V say that there is no lack of desire to participate. It is very difficult to do it. It is very difficult to figure why am I submitting the kind of information they require since they give me no justification or no playback. They justify it on the basis that it represents their responsibility to execute accountability back to Congress.

So we would prefer to see that there be some more attention paid to the sanity of the regulations and to simplicity rather than trying to allow virtually anyone who has an ambition to add another element of information to further complicate the system.

Senator KENNEDY. I think I would have trouble differing with anything that you mentioned there or arguing with it. I think what we have seen is, for whatever reason, an increasing number of pediatricians are opting out of the medicaid system. That has been true.

Dr. CORNELY. That is very easy to understand in regard to mediaid. EPSDT in 22 States prohibits anyone from the State or local health department from delivering EPSDT service—your State is an exception, your State allows private practitioners to participate. In 22 States, the Governors have said the most inexpensive way in which I can implement this is to use my own established health program. So they have well-baby clinics. They convert them into screening clinics. The CHAP legislation said that it not enough. It should move, giving not just screening, but also provide diagnosis and treatment. It also suggests that there is to be a deliberate attempt to move private practitioners back into it. Confusion results because at the State level the Governors are in a quandry. How can they meet their budgets and pay their bills unless they do it in the most inexpensive way. It is not as expensive to do it through their own clinics as it is to go through private practitioners.

Senator KENNEDY. That is certainly an explanation in those areas which have those provisions. I think you would find the track records in the remaining 28 States not dissimilar from the ones you have outlined here. I may be wrong.

We will put that part in the record on that, but I think that that has been a concern. It might be for reasons you have outlined here before, but it is a trend, it is development and movement which is obviously a very substantial concern.

Senator CHAFEE. I would just like to comment a little bit on Ms. Schorr's testimony. I must say I was stunned to read on page 2 of your testimony that 20 million children, 39 percent of the total under age 15, are not immunized against one or more of the six potentially dangerous childhood diseases for which vaccines are available. This certainly comes as a bit of discouraging news.

When you think of everything we are doing with community health centers, HMO's, medicaid and other programs which we seem to pour out of this Government yet we are not doing what seems to be

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minimal on preventive measures. I do not have a solution. All I can say is I just wonder what is happening out there in the big world with all the money and effort and a whole host of programs, 1 zillion Federal programs. I do not have an answer to my question. I am just discouraged.

Ms. SCHORR. A very brief comment. The Secretary of HEW shares your concern and has undertaken new initiative to get more children immunized. Their goal, I think, is 90 percent of the children within another year or two. I think in your comments you really highlighted what the problem is. That is we have 1 zillion programs, and they are not adequately coordinated so that needed services get to the families in the communities in ways they can make use of them. I think that is what we are asking you to do, to look at these programs and see what has to be done to them so that the famly is in a better position, has better access to sources of immunization, and other needed care.

Immunization rates have been going down. They have not been going up. They have been going down over recent years.

Senator CHAFEE. It seems that is about the easiest thing to do is to immunize children. Then, on page 3, you get into another area of great interest to me, the lack of attention to pregnant women, including teenagers; 7 out of 10 mothers under 15 get no prenatal care in the first trimester and one-fourth get no prenatal care at all, twice as many blacks—I do not know what the answer to this is. I would think community health centers would be doing a lot.

Ms. SCHORR. We do know that the neighborhood health centers and maternal and infant care centers have a quite different record in terms of the number of women they get into care early.

Senator CHAFEE. Different from what?

Ms. SCHORR. A far better record than these nationwide figures. We know it is possible to do, that if you combine outreach services with the services of not only obstetricians but nurse-midwives, and other health workers, community workers, put those together and make them readily available in neighborhoods where people live, get information out about them, and deliver the services in circumstances where there is no racial discrimination, where steps have taken to overcome language and cultural barriers, where the client or patient is treated with dignity and respect, we know that it is possible to get women in early in their pregnancies and provide high quality prenatal care. It has not happened everywhere, it doesn't happen without clearly focused efforts.

Senator CHAFEE. You do not know how these statistics work out in different sections of the country? It would seem to me in the great area of blue western sky, say a place like Idaho, I just cannot believe these figures would apply there. I can see some of the areas in the great urban centers, where these statistics might be true. Give me some encouragement.

Ms. SCHORR. The statistics are available by States. They are collected by the National Center for Health Statistics and are available by State. Perhaps we could make them available to you for the record.

Senator CHAFEE. I am curious, we must be doing a decent job somewhere in this country in preventive medicine. I would like to

think we are, but your statistics do not give me much for celebration.

Ms. SCHORR. There is no question but that we are doing a decent job with groups of people, defined groups of people reached by organized community programs. Whether there are whole States that can claim that they are reaching all their pregnant women early in their pregnancies, perhaps Dr. Cornely or Dr. Miller could clarify.

Dr. CORNELY. I will mention a few States. Take the State of Nebraska. They have publicly supported services for pregnant women in two cities, Lincoln and Omaha. Beyond that, everything is out-of-State. There are no publicly sponsored services out there for pregnant women. The women in those areas of the State are expected to go to local practitioners, and if they do not, no one knows about it. You go to West Virginia, you find precisely the same picture. So this is not a dramatic event any more than immunization is a dramatic event.

So stimulus for people to get these services, I suppose, requires a tremendous, aggressive approach to try and sell through outreach preventing services.

[The prepared statement of Dr. Cornely and the health statistics referred to earlier follows:]

AMERICAN ACADEMY OF PEDIATRICS

Testimony before the

Human Resources Committee
Subcommittee on Health and Scientific Research

Presented by

Donald A. Cornely, M.D., FAAP
March 1, 1978

Maternal and Child Health in the U.S.A.*

The American Academy of Pediatrics appreciates this opportunity to offer commentary to the Subcommittee on Health on the matter of public responsibility for the health of children of this country. Members of this Subcommittee should understand that this topic of public responsibility for the health and welfare of mothers and children is not a new found interest of the American Academy of Pediatrics. Our Academy was formed in 1930 and one of the factors prominent in the decision of our formation was the interest of the pediatricians of this country to support the concept of federal-state grant-in-aid to focus on the health and welfare of mothers and children. We deem it important to note that the first federal-state grant-in-aid program in health in this country was for maternal and child health. This concept has been given expression in the Social Security Act of 1935 and Title V of that original Act addressed maternal and child health and continues in force today. Thus, five years before Congress formulated the current organizational legislation to promote the health of mothers and children the American Academy of Pediatrics was formed and adopted our motto, "For the Welfare of Children."

Over the past 65 years Congress has taken several actions to express its commitment to the public responsibility for child health. We wish to call your attention to four of these actions which can assist in understanding our current posture and offer a perspective for

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*Testimony presented before Senate Subcommittee on Health, Wednesday, March 1, 1978 on behalf of the American Academy of Pediatrics. Donald A. Cornely, M.D. presenting.

future developments. Certainly, the formation of the Children's Bureau in 1912 represents an important landmark. An admirably broad view of child health and its interrelationships with child welfare was expressed in the charge given by Congress to the Children's Bureau. The second significant guidepost was the Social Security Act of 1935. As mentioned earlier, one of the original Titles of this Act (Title V) isolated the concern and commitment of Congress for child health. This Title bears its original name, Maternal and Child Health and Crippled Children's Services. It mandates in every state the formation of a distinct administrative unit to focus on the promotion of the health of mothers and children and for children with chronic handicapping conditions.

It is well at this point to emphasize that the major thrust of Title V from its inception has been to prompt the formation of a technically competent body in each state addressing the breadth of issues involved in advancing the health of the maternal and child populations. The appropriations provided by Congress each year in the form of grant-in-aid to implement this Act add further recognition of Congressional intent that the MCH and CC units in each state are to engage in a very broad set of activities determined by each state commensurate with its needs and resources. The appropriations, currently approximately $400 Million, support the operation of these state units and selected programmatic efforts addressed to special problems and issues affecting the health of mothers and children. Equally important to understand is that the level of appropriations never has suggested that Title V of the SSA was to be the financial system to support health services needed even by just this country's

poor children and mothers. Title V programs stimulate the organization of programs, assist in their development and integration into the total fabric of health services and explore through demonstrations and special projects the resources and arrangements needed to address specialized needs of this population segment.

The third significant action by Congress relative to child health was the identification and development of the National Institute of Child Health and Human Development in 1963. By this action, Congress gave recognition to the critical need to invest in a long term commitment to advancing the health of the fetus, child and youth. Without this basic research arm to complement the health service activities of today it would be futile to expect to achieve the level of health this country holds out for its children. While a small portion of Title V appropriations are mandated and utilized for research focused on the delivery of health services for this population, the separate complementary mission of the NICHD of research on fundamental biological and behavioral relationships affecting health and development has been a prudent perception by Congress.

The fourth action of Congress we choose to identify that is relative to the public responsibility for maternal and child health was the passage in 1965 of Title XIX of the Social Security Act and its subsequent amendment of 1967 addressed to early and periodic screening, diagnosis and treatment for children who are classified as poor. This Medicaid program is reported to spend between $3 and 4 Billions annually for personal health care services for children. It is helpful in understanding the nature of existing deficiencies

in our maternal and child health programs to note the magnitude of tax supported expenditures for this population group when distinguishing Titles V and XIX of the SSA. Congress has appropriated approximately $300 Million annually for Title V programs and when matched by state and local funding it might identify a total of $500-600 Million. Title XIX reports $3-4 Billion spent annually for personal health services to eligible poor children. It is clear that the intent of these two Congressional mandates are different, however complementary they might be perceived. Title V was never intended to be the means by which even poor children were to receive their personal health services. Title XIX is intended to provide for such services to eligible poor children, however restricted the definition of eligibility.

These four actions by Congress over slightly more than the past half century are selected to highlight on one hand that Congress has recognized the need for special attention to the health of mothers and children while on the other hand to indicate the decidedly timid and halting nature of the commitment which has resulted in unnecessary fragmentation and insufficient health services. Add to these four, more-or-less major milestones in child health, the numerous legislative actions on more circumscribed diseases or conditions affecting children and the potential for fragmentation is increased without assurance of adequacy of coverage for all the health needs of all children.

When one moves to the implementation of these legislative intents by the Executive branch of our federal government,

theorized inadequacies become more realities. Focus for the moment on the major site of the federal administrative implementation of maternal and child health programs, the Department of Health, Education, and Welfare and examine its response in organizing its resources for maternal and child health. Members of Congress might start by reflecting on when was the last time any of its Committees had the opportunity to have the director of DHEW's maternal and child health program address them or be present for any desired discussion. We believe you will find this last occurred over five years ago. Within DHEW the effort for maternal and child health is diversed rather than focused and the office bearing the specific identification of maternal and child health programs is buried at least three layers beneath that of the Assistant Secretary for Health. Thus, the administrative placement of the MCH program office, the scatter rather than coalescing of efforts for this focus and the sheer confusion and effort expended in an almost chronic preoccupation with reorganization has resulted in less progress than can long be tolerated.

A very concerning administrative reality has been that in its twenty-five years as a Department, HEW has had about a dozen different Secretaries. If this is to be the experience we must expect, then we suggest Congress take steps to insulate its commitment to maternal and child health from the very real risks of neglect or limited understanding any new administrative arrangement might install. A distinct administrative unit in DHEW charged with that same responsibility embraced by Congress in its Title V of the SSA mandate to each state would seem to be both reasonable

and imperative. It would lessen the hazard of fragmentation of responsibility, leadership and direction which has very significantly handicapped the efforts of implementation during this decade. This distinct unit should be placed immediately under the Assistant Secretary for Health.

Congress could also strengthen the implementation capability for its mandate by identifying this MCH Program Office as the administrative site for those programs it generates whose focus is principally or primarily child and maternal health. The Academy is mindful of the wisdom in the separation of legislative and administrative powers and prerogatives in our system of government and does not intend its suggestions to impair that distinction. However, with the Secretaries of DHEW being somewhat transient in that position, with by far the major funding in the Department understandably compelling the Department's attention to the needs of other age groups and issues of very limited applicability to children, a structural arrangement seems both reasonable and prudent in insuring adequate attention to the health programs for children. Consider the major issues both Congress and the Department have been diligently struggling with in the area of health in these times. Cost containment, control of fraud in the medical care programs and national health insurance are not issues prompted by a major concern for child health. Cost containment isolates short term hospitalization and nursing homes and these are not major components of a maternal and child health program, however important they be to the broader health program. Children frequent the inpatient side of hospitals

very infrequently and have the lowest rate of hospitalization, the fewest days of hospitalization of any age group, and the differences are of great magnitude. Fraudulent use of public funds for health care can hardly be presented as a major problem in maternal and child health since health services to these population segments is essentially a preventive and ambulatory orientation. We do not experience an overuse of preventive health services for women surrounding maternity care or family planning services, and for children and youth. Quite the contrary, our struggle has been and remains to attempt to have children and mothers-to-be to utilize even minimum services. Members of this Subcommittee know very well that if the costs involved in considering national health insurance were those projected for the maternal and child population needs, there would be little hesitancy in moving aggressively forward with a universal entitlement. Thus, children and their health needs tend to get lost in the complex of large expenditures and services required to serve the general (older age groups) population. Unless Congress takes the step to add a significant and appropriate structural base for maternal and child health in our federal health administration, the Academy feels we as a nation simply fail to understand and meet our responsibility to children.

One could recite a list of specific health problems facing the maternal and child population at this time. Obvious in such a list would be the concern about pregnancy in the young adolescent female; the higher than necessary infant mortality rates in at least one-third of the states; the precarious arrangements or lack thereof for appropriate personal health care of families who are poor, who reside

in urban and in rural settings; the near absence of appropriate maternal health services during the prenatal period in vast sections of this country and so on. Moving to universal entitlement under some form of national health insurance will itself not address each of these issues adequately. However, until the financial impediment to achieving appropriate personal health care is removed, millions of children simply lose valuable and needed skills and talents to be productive adults.

The Academy has examined somewhat extensively two programs generated by Congress which focus on maternal and child health. The Title V and EPSDT Programs were reviewed and continue under discussion. We are aware that legislatively each of these programs are under the authority of the Senate Finance Committee. Our comments have been shared with that Committee in a preliminary fashion and we expect a more thorough discussion in the near future.

The Title V program suffers badly from the limited understanding at many levels of federal, state and local government of its primary purpose. Earlier in this testimony the contrast in levels of expenditures between Title V and Title XIX programs was made explicit. Both the wording of the respective mandates as well as the levels of funding should enable one to understand that Title V has as its principal mission the development of a sufficient capability in each state to address the general issue of the health status, health needs and health services for mothers, children and children with handicapping conditions. Special groups and special efforts in the form of specified projects and demonstrations are to be pursued in the states. Each state, however, must develop an appropriate plan of its needs and intended pursuits to minimize or remove health needs

and problems. In addition, the assessment of the health of this population, the development of resources, the deployment of special resources, the promulgation of standards of care, the stimulation of attention to the health of mothers and children, case finding, coordination of public and private initiatives in health for this population group are the scope of responsibilities of the Title V programs in each state. The Academy finds these state plans to be inadequate in most jurisdictions and it appears to be the result of a lack of understanding of this mission and inadequate financial support to develop the needed capability to respond to this charge. We tend to feel that redrafting this fundamental piece of legislation would be the better approach to add the clarity, provide the technical capability, and to develop the needed national, state and local resources.

The EPSDT Program has been described by many as a debacle and it is not difficult to support such a contention. Data is sparse but what is available certainly suggests that the EPSDT Program suffers very badly from lack of direction, lack of technical competence in the central and regional federal offices, oppressive regulations and policies all of which result in but a fraction of the eligible children being served at all, much less adequately. The Administration's proposal to convert this into a Comprehensive Health Assessment Program generally moves in the correct direction but until the Congress has given it a more thorough review it would seem reasonably futile to enumerate specific questions and problems in the proposal at this time.

The American Academy of Pediatrics is prepared to provide appropriate bodies of the Congress its insights and recommendations in more complete detail when they are prepared to address these issues.

THE NATIONAL FOUNDATION-MARCH OF DIMES

Percent of Liveborn Whose Mothers Began Prenatal Care Each Trimester and Percent Weighing 5½lbs. or Less, by Race, 42 States and D.C., 1974

Region and State	Trimester In Which Prenatal Care Began					
	Total	First	Second	Third	No Prenatal Care	Not Reported
Total, 42 States & D.C.						
All Births						
% of total	100.0	69.2	20.8	4.6	1.3	4.1
% low weight	7.4	6.6	8.6	8.6	20.1	9.7
White Births						
% of total	100.0	73.0	18.3	3.9	1.0	3.8
% low weight	6.3	5.8	7.0	7.1	16.3	7.7
Nonwhite Births						
% of total	100.0	52.3	31.6	7.9	2.7	5.5
% low weight	12.4	11.3	12.6	11.5	26.3	15.6

☐ *Impaired fetal growth* results in a "small for date" baby, who is born at full term (9 months), but with low birthweight. Poor maternal nutrition during pregnancy may be associated with slow fetal growth. These infants suffer *in utero* from poor nutrition, poor oxygenation and other adverse conditions.

☐ *Prenatal care and low birthweight.* While prenatal care is not the only influence on birthweight, its importance is obvious wherever data on the outcome of pregnancy have been examined.

In a recent study in New York City, this was true even among women whose social and medical histories gave every indication of a favorable outcome. They were married, had finished high school, had no history of previous fetal deaths and had no complications during labor or delivery.

This study was based upon live births to women whose ages ranged from less than 15 to as high as 39. *In all age groups,* low birthweight and infant mortality rates were markedly higher among the mothers who had no prenatal care, whether or not they were at these social or medical risks.

The results were especially revealing for teen-age mothers. Among teen-agers whose pregnancies were not at these social and medical risks, low-weight ratios varied from 5.5 per cent for those who began care in the first trimester, to 8.5 per cent when care started in the second and third trimesters, to 9.9 per cent for mothers who had no prenatal care at all.

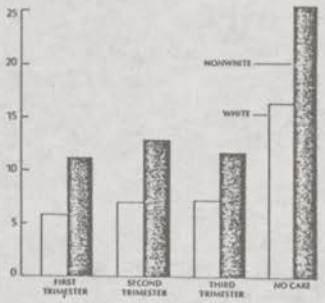
Among teen-age mothers with high-risk pregnancies, the low-weight ratios also reflected the influence of prenatal care, varying from 15.4 per cent of births to high-risk mothers whose medical care began during the first trimester, to 23.1 per cent among such women who had no care at all.

Percent of mothers who began prenatal care in the first trimester, 42 reporting states and D.C., U.S.A., 1975

State	Percent	State	Percent
Rhode Island	86.3	Minnesota	72.8
Utah	85.7	North Dakota	72.5
Connecticut	85.2	New Jersey	71.9
Iowa	82.0	Nevada	71.2
Wisconsin	81.8	North Carolina	71.2
New Hampshire	78.5	Illinois	70.5
Maryland	77.9	Kentucky	69.8
Ohio	77.8	Tennessee	69.7
Montana	77.8	Vermont	69.3
Virginia	77.2	Texas	68.9
Delaware	77.0	Hawaii	68.9
Kansas	76.5	Mississippi	68.6
Indiana	75.7	New York	68.5
Maine	75.5	Georgia	67.7
Michigan	75.3	South Carolina	66.8
Oregon	75.3	Oklahoma	66.6
Nebraska	75.3	Florida	65.5
Missouri	74.8	South Dakota	64.3
Colorado	74.5	West Virginia	60.9
Wyoming	73.9	Arizona	60.1
California	73.0	District of Columbia	56.6
Louisiana	72.9		

Source: National Center for Health Statistics

Percent of newborns weighing 5 lbs. 8 oz. or less by trimester in which mother began prenatal care 42 reporting states & D.C., 1975



Infant deaths. Americans take our role as world leaders almost for granted. We are first in space technology, agricultural production and industrial development. Our men and women of medicine have made lasting contributions to the health of all mankind.

But in protecting human life at birth, those first, fragile days of life, we have fallen behind other advanced nations for many years. We have a higher infant death rate than 16 other countries.

This poor showing cannot be explained away by international differences in definitions and reporting standards. The MOD believes that our disproportionately high rate of infant death could be reduced significantly if all pregnant women received early, continuous prenatal care, including adequate nutrition.

Hence our expanded efforts — as reflected in the recently adopted resolution by the NF Board of Trustees — to make prenatal care widely available and accessible, better understood and utilized.

The outcome of pregnancy is strongly influenced by a variety of social, cultural and demographic risk factors such as income, education and accessibility of medical care. The disadvantaged, the undereducated, the ethnic minorities, in general, experience poorer outcomes than others.

Senator CHAFEE. Thank you, Mr. Chairman.

Senator KENNEDY. Thank you.

Ms. SCHORR. Thank you.

Senator KENNEDY. With the understanding of our good friend, Mike Gorman, I am going to ask that we take the Panel on Comprehensive Public Health Programs.

We have Robert Whalen, Commissioner of Health, New York State, Albany, N.Y.; accompanied by Joseph E. Cannon, M.D., Director of the Department of Health, Providence, R.I., and James E. Word, Deputy Commissioner, State Department of Health, Nasville, Tenn.; and Dr. Donald Wallace, Health Officer, Prince Georges County Health Department, Cheverly, Md.

Senator CHAFEE. Mr. Chairman.

I am pleased to see we are examining one of the few Federal programs which addresses a sorely neglected subject—that of health protection and disease prevention. I think that if we put just a fraction of the money into prevention that we do into costly medical care, we could do a great deal to improve the health of the people of this country. Prevention is so much more desirable than cure, and I am concerned that we are taking for granted the importance of organized public health protection programs—as evidenced by the lack of adequate funding in recent years for Comprehensive Public Health Services under section 314(d).

Because we no longer worry about many of the killing and disabling diseases of yesterday—and this is due in large measure to the fine job our public health departments around the country have done—we must remember that the need for organized community health programs has not diminished—on the contrary, the increasing environmental hazards will put a great burden of responsibility on our hard-pressed public health officials in the future.

As you know, I have recently introduced a bill, S. 2567, which amends 314(d) of the Public Health Service Act to increase Federal support for public health programs and to encourage State and local governments to increase their spending for these programs. My bill would provide a floor of guaranteed Federal support, but would grant not more than 10 percent of state and local expenditures for these activities up to a ceiling of $1.50 per capita. I have included a floor of $1 per capita for each State's allocation, and while this is a modest figure compared to the amount the Federal Government spends on treatment for illness, this might bear some further investigation. However, the concept of this bill—that of a shared Federal-State-local commitment to organized community health protection programs represents an essential new national emphasis on sickness prevention. My bill would preserve the flexibility which the 314(d) block grant program gives to States to deal with unique regional needs. It also continues to allow for a comprehensive array of public health programs which would not be possible with a patchwork of narrow categorical disease prevention grants.

I welcome the comments of the witnesses here today on this concept, as well as the views and recommendations of all other interested parties.

Senator KENNEDY. Dr. Whalen.

28-386 O - 78 - 20

STATEMENTS OF ROBERT P. WHALEN, M.D., COMMISSIONER OF HEALTH, NEW YORK STATE, ALBANY, N.Y., ACCOMPANIED BY JOSEPH E. CANNON, M.D., DIRECTOR, DEPARTMENT OF HEALTH, PROVIDENCE, R.I.; JAMES E. WORD, DEPUTY COMMISSIONER, STATE DEPARTMENT OF HEALTH, NASHVILLE, TENN.; AND DONALD WALLACE, M.D., HEALTH OFFICER, PRINCE GEORGES COUNTY HEALTH DEPARTMENT, CHEVERLY, MD., A PANEL

Dr. WHALEN. Senator Kennedy, Senator Chafee, I am Dr. Robert P. Whalen, commissioner of the New York State Department of Health. I am before you today representing the Association of State and Territorial Health Officials, also known as ASTHO.

May I begin by thanking you and your colleagues for the wisdom and support which brought the partnership in health program into being 11 years ago. Through your foresight, you helped to establish the common responsibility of Government on all levels—Federal, State and local—to work together to pursue initiatives to improve and protect the health of the American people. We believe the health advances of the past decade bear eloquent witness to the value of Federal block grants for community and State public and preventive health programs.

Partly as a result of these advances, an infant born today in the United States has an average life expectancy of 73 years; our infant mortality rate is the lowest in the Nation's history; and in the past 14 years, we have seen a 25-percent decline in rate of death from our No. 1 killer, coronary artery disease. Since 1900, there has been an age-adjusted 61-percent reduction in our Nation's overall death rate.

Much of the credit for these advances belongs to our public health departments who have carried out relentless—and often unduplicated—campaigns to protect the people's health and prevent sickness and death.

It is on the basis of this record that we State health officials believe the time has come to enlarge our efforts in the fields of disease prevention and health protection. In short, we believe it is time that we matched our health rhetoric with dollars, and time that the States were more equal partners in the Federal-State health partnership.

Fifty or 100 years from now, if an historian were to look back at our current health spending policy, I suspect he or she would come to the conclusion that we were unable to tell the difference between sickness and health. For, in our zeal to treat sickness, and to pay for the cost of this treatment, there exists the clear and imminent danger of ignoring our essential objective—the achievement of optimum health and well-being through the prevention of illness.

Last year, the Federal Government spent over $45 billion on health, by far the greatest share of it on sickness treatment. Yet the Federal investment in basic health preventive and protective services is at low ebb, standing at less than 50 cents per person yearly, out of a total Government health outlay of some $270 per person per year.

In the light of these sobering economic data, the Association of State and Territorial Health Officials recommends the enactment of legislation to provide for a national health protection system, one

that will generate a new health incentive plan for the all of our States and all of the American people.

Senator KENNEDY. Doctor, we are supposed to recess at 11 o'clock because of the Panama Canal debate. We are going to extend the time a little bit after that. We have another panel so we would include your statement in its entirety in the record, and if you could highlight it.

Dr. WHALEN. I will make a few remarks, Senator.

Senator KENNEDY. We apologize for the inconvenience.

Dr. WHALEN. I believe you asked the question were 314(d) funds merely a slush fund. I think we as responsible public officials fully understand that the same thing we demand of providers in the health care field, we must demand of ourselves. We stand fully ready to account for whatever funds are given to us and have been active in partners with the Federal Government in developing the reporting system which outlines the disposition of 314(d) funds.

I would like to leave a copy of that latest report for the record.

We also recognize we must be kept to standard also and have been actively participating with the Center for Disease Control in the implementation of the legislation of last year requiring the development of standards for public health programs throughout the country.

We do not come before you to say that every health department is as good as it could be or as good as it can be. We would like to point out that we have been faced with 314(d) funding, which has not increased over a decade and has been eroded to 50 percent of the level of the real dollars that were available to us in 1966.

In addition to that, in a good many of States, particularly those in the Northeast, we have been faced with severe——

Senator CHAFEE. What is that figure again? Give us that dollar figure based on what you are getting.

Dr. WHALEN. It has been a level appropriation. It is $90 million nationwide.

Senator CHAFEE. It is a level in dollar, not a level in inflated dollars?

Dr. WHALEN. That is correct.

Senator CHAFEE. In effect, you are getting less?

Dr. WHALEN. That is correct.

Now, we also have been faced, particularly in the Northeast, and particularly my own State of New York, with fiscal constraints on the State scene which came about because of absolute necessity. I think it is very difficult for a health officer today to sit in his State and see the things that ought to be done that are quite cost beneficial and be unable to do them.

Let me give you a few quick examples. Tomorrow, if I were given the funding, I would immediately start newborn screening for hypothyroidism. We can expect 1 child in 8,000 births to have hypothyroidism. This would be a preventive program which would save many dollars in the long run by preventing a lifelong episode of mental retardation for a child and the severe anguish it causes for the family. I think we could mount a program tomorrow costing less than 50 cents per school child to move to chloride mouth rinses in

those school districts where fluoridation is either not possible or has not been adopted.

I think we should be doing more in the field of toxic substances in our environment. There are few States which have not been faced with this problem in one way or another. We face the limitation of laboratory capacity to adequately monitor it. We face the inadequacy of a corps of toxicologists who can spell out for us what those human health hazards are, particularly those that affect a pregnant woman and a newborn child.

I think in most areas of the country our school health programs require complete reexamination, a complete change of approach. If we are going to administer EPSDT, we should look at the 25 percent of the population in our States which is in our school system each day. We should look at the type of school health education we are giving to them. Our schools could become primary health care providers.

Senator CHAFEE. In your State do you provide that service in your schools for your youngsters in parochial schools?

Dr. WHALEN. Yes; in parochial schools also, Senator.

Senator KENNEDY. Let me ask, Doctor, it is interesting in how you might spend the money, additional money, why do we not take what you have gotten this past year or last year? You get about $5 million.

Dr. WHALEN. $5 million.

Senator KENNEDY. Why do you not tell us how much of that has been in terms of services, what percentage of that is in terms of services?

Dr. WHALEN. There is a mandate in the present grant that 70 percent be devoted to local health services. These are utilized largely to staff our district offices in the park areas of the State, Adirondack Park and Catskill State Park. They largely support sanitary engineering services and supervising public health nursing services to those counties which are largely rural and low in population and have no local health services of their own. That is where the bulk of our funds is going.

Senator KENNEDY. Well, how much of that is in salaries——

Dr. WHALEN. I would have to guess, Senator. I would guess that probably 75 percent is in salaries.

Senator KENNEDY. 75 percent?

Dr. WHALEN. Yes.

Senator KENNEDY. Would you provide that for us? I would be interested in all of you providing what is happening in terms of the States.

Dr. WHALEN. Fine.

We can, Senator, leave with you for the record tabulations which indicate what is being done with the funds in each State.

I think those are the major points I would make. There are many things cost beneficial, and they are not going to be done unless we match our rhetoric with our dollars.

[Information subsequently supplied for the record follows:]

NEW YORK STATE DEPARTMENT OF HEALTH
COMPREHENSIVE STATE HEALTH PLAN - (BLOCK GRANT)
314d FY77
Statistics

Personal Service including Fringe Benefits	72%
Other than Personal Service	28%
	100%

Program Expenditures	%	$
Personal Health Program	22.69	1,017,739
Laboratory Program	.81	36,049
Environmental Health Programs	29.82	1,337,567
Health Resources Program	5.98	268,104
General Administrative Services	40.70	1,825,476
Totals	100.00	4,484,935

National Public Health Program Reporting System
Washington, DC (202) 265-4350

Part III - Inventory of Health Programs

New York

CLASS CODE (10)	SET NUMBER (20)	PROGRAM TITLE (30)	FY 77 TOTAL PROGRAM EXPENDITURES (40)	FY 77 EXPENDITURES FOR INPATIENT CARE, IF ANY (50)	FY 77 314 (d) PROGRAM EXPENDITURES PUBLIC HEALTH (60)	MENTAL HEALTH (70)	HYPER-TENSION (80)
Personal Health Programs							
301	01	L.A. Public Health Program	38,966,978				
302	02	Epidemiology	12,555,287				
306	03	Public Information	434,085		22,868		
310	04	Child Health Direction	272,272		16,132		
310	05	Maternal & Child Health	942,220				
318	06	Family Planning	2,718,991				
319	07	Supplemental Nutrition and MCH Nutrition	16,908,926		18,685		
320	08	Birth Defects	747,663				
322	09	Cancer Control	1,408,614		44,105		
326	10	Kidney Disease Institute	1,414,005				
328	11	Burns Care Institute	78,617				
330	12	Acute Communicable Disease Control	358,728		2,130		
331	13	Immunization	928,261				
333	14	Hypertension	42,777				0
333	15	Respiratory Disease	801,852		744,382		2,394
34	16	Venereal Disease Control	615,538				
40	17	Medical Rehabilitation	1,266,234				
80	18	Dental Health	760,622				
391	19	Migrant Health Services	133,121		98,717		
393	20	Indian Health Services	328,224		50,910		
		Total Personal Health	99,077,998		1,017,729		2,394

The Association of State and Territorial Health Officials
National Public Health Program Reporting System
Washington, DC (202) 265-4350

Part III - Inventory of Health Programs
New York

CLASS CODE (10)	SET NUMBER (20)	PROGRAM TITLE (30)	FY 77 TOTAL PROGRAM EXPENDITURES (40)	FY 77 EXPENDITURES FOR INPATIENT CARE, IF ANY (50)	FY 77 (3146) PROGRAM EXPENDITURES: PUBLIC HEALTH (60)	MENTAL HEALTH (70)	HYPER-TENSION (80)
Personal Health Programs - VHA Operated Institutions							
440	22	Helen Hayes Rehabilitation Hospital	8,259,581	8,116,859*			
440	23	Roswell Park Memorial Institute	49,661,996	34,874,224*			
460	24	NYS Home for Veterans & Their Dependents at Oxford	2,119,002	2,119,002			
		Total VHA Operated Institutions	60,040,579	45,110,085			

*Expenditures for All Patient care & research

Part III - Inventory of Health Programs

New York

CLASS CODE (10)	SET NUMBER (20)	PROGRAM TITLE (30)	FY 77 TOTAL PROGRAM EXPENDITURES (40)	FY 77 EXPENDITURES FOR INPATIENT CARE, IF ANY (50)	FY 77 314 (d) PROGRAM EXPENDITURES: PUBLIC HEALTH (60)	MENTAL HEALTH (70)	HYPER-TENSION (80)
Laboratory Program Area							
500	25	Laboratories & Research Administrative Services	3,434,101		2,702		
501	26	LA for Laboratories and Blood Banks	3,791,304				
510	27	Infectious Disease Center	5,328,173		33,197		
510	28	Clinical Laboratory Center	3,464,144		48		
510	29	Medical Genetics & Counseling Cytology	418,885				
510	30	Embryology & Development Program	85,723				
510	31	Molecular Biology & Biophysics	123,318				
511	32	Clinical Laboratory Evaluation Center	314,739				
520	33	Environmental Health Center	1,608,723				
521	34	Safe Drinking Water Lab Certification	16,051				
521	35	Environmental Health Center-Quality Control	1,619,237		97		
		TOTAL LABORATORY PROGRAM	22,204,209		36,049		

The Association of State and Territorial Health Officials
National Public Health Program Reporting System
Washington, DC (202) 265-4330

Part III-Inventory of Health Programs
New York

CLASS CODE (10)	SET NUMBER (20)	PROGRAM TITLE (30)	FY 77 TOTAL PROGRAM EXPENDITURES (40)	FY 77 EXPENDITURES FOR INPATIENT CARE, IF ANY (50)	FY 77 314 (D) PROGRAM EXPENDITURES		
					PUBLIC HEALTH (60)	MENTAL HEALTH (70)	HYPER TENSION (80)
Environmental Health Program Area							
620	37	Food and Drug Direction	254,173		160,281		
620	38	Food Protection	171,780		160,280		
630	39	Sanitary Engineering	85,066		8		
635	40	Housing Sanitation	201,059		89		
636	41	Recreation Sanitation	201,059		89		
637	42	Bureau of Community Health Services Sanitation	2,951,685		376,333		
637	43	Invertebrate Vector Control	226,337		142,708		
641	44	Occupational Health	15,037				
650	45	Radiological Health	460,327		367,398		
671	46	Public Water Supply	528,316		130,341		
671	47	Safe Drinking Water Program	251,909				
		TOTAL ENVIRONMENTAL HEALTH PROGRAM	5,346,948		1,337,567		

Part III-Inventory of Health Programs

New York

CLASS CODE (10)	SET NUMBER (20)	PROGRAM TITLE (30)	FY 77 TOTAL PROGRAM EXPENDITURES (40)	FY 77 EXPENDITURES FOR INPATIENT CARE; IP ANT (50)	FY 77 314 (d) PROGRAM EXPENDITURES: PUBLIC HEALTH (60)	MENTAL HEALTH (70)	MIFEX-TENSION (80)
Health Resources Program Area							
701	48	LA for Health Resources Program	24,403,733				
704	49	Narcotic Enforcement	210,345				
706	50	Controlled Substances	145,082				
711	51	Health Planning Activities	800,449				
711	52	Resources Management	488,074				
720	53	Appalachia Projects	1,206,395				
724	54	State Health Research Council	2,112,988				
730	55	Home Health Services	535,058				
731	56	Health Care Standards	78,788				
731	57	Health and Medical Care Standards	1,200,329				
731	58	Program Coordination Group	3,370,169		24,725		
731	59	Health Services	5,264,040				
737	60	Reimbursement Rate Setting	1,021,925				
737	61	Economic Analysis	274,045				
737	62	Audits and Investigations	1,875,193				
737	63	Financing	1,452,321				
738	64	Medicaid Administration	7,132,158		58,863		
740	65	Health Manpower - Direction	234,604		47,544		
740	66	Medical Manpower	31,541		21,804		
740	67	Veterans Health Manpower	86,546				
741	68	Nursing Home Administrator Licensure	87,187				
741	69	Funeral Directing Regulation	220,107				
741	70	Professional Medical Conduct Review	369,244				
742	71	Radiological Technology	145,032				
752	72	Vital Records	716,339				
753	73	Biostatistical Services	849,310				
760	74	Emergency Medical Services	1,913,392		115,319		
		TOTAL HEALTH RESOURCES PROGRAM	60,093,436		368,104		

The Association of State and Territorial Health Officials
National Public Health Program Reporting System
Washington, DC (202) 265-4150

Part III -- Inventory of Health Programs
New York

CLASS CODE (10)	SET NUMBER (20)	PROGRAM TITLE (30)	FY 77 TOTAL PROGRAM EXPENDITURES (40)	FY 77 EXPENDITURES FOR INPATIENT CARE, IF ANY (50)	FY 77 314 (D) PROGRAM EXPENDITURES PUBLIC HEALTH (60)	MENTAL HEALTH (70)	HYPER-TENSION (80)
General Administration and Services							
8000	75	Executive	399,859				
8000	76	Financial and Administrative Services	4,008,401		3,878		
8000	77	Employee Relations	51,592		49,393		
8000	78	Data Processing	1,500,294		46,184		
8000	79	Legal Services	1,391,445		16		
8000	80	Health Communication & Education	257,392		41,603		
8000	81	Regional and Local Health Management	2,364,925		1,682,402		
		TOTAL GENERAL ADMINISTRATION AND SERVICES	9,973,908		1,825,476		
TOTAL NEW YORK			254,737,078		4,484,935		2,394

THIS FORM IS PAGE 11

Senator KENNEDY. Dr. Cannon, you are surrounded by two good Rhode Island Senators here. Would you like to say a word?

Dr. CANNON. Yes. I am delighted to see both Senators here, one a Republican and one a Democrat.

Senator KENNEDY. No partisanship on this committee.

Dr. CANNON. I have had the pleasure of serving under Governor Chafee—Senator Chafee while he was Governor, and while he was Governor, and I hate to say this before any Democrats, but he was one of the finest Governors that I have seen because he had a concern for people.

Senator CHAFEE. Do not be reluctant to say that at all. [Laughter.]

Dr. CANNON. I think, Senator, I have a statement that I would read, and it is brief. I would like to say a couple of things. That as a result of the block grant money, and I worked in 1964, 1965, and 1966 with a small group of health officers with the Surgeon General's office. It did not come out the way we expected.

The block grant money in the State of Rhode Island, and I must confess that all States are different, including Rhode Island. There is a place, by the way, for some people who do not know, it is a place called Rhode Island——

Senator CHAFEE. Pull the microphone over closer.

Dr. CANNON. There is a place called the State of Rhode Island Private Plantation. We are able to do things there in a simple way. We are very simple people. Perhaps I am the most simple of most. We do use block grant money to develop new things. For example, the HMO program in Rhode Island really started as a result of block grant money.

We had some 27 nurse associations that gave scattered and fragmentary home health services. We were able to cut the nurse agencies to nine and develop uniform accounting systems and referral systems and reporting systems that they all use now. We developed with block grant money the first home health agency concept in Rhode Island, and that has been a continuing effort now on the part of most. These are things that would never have happened without that block grant money.

It gives us the flexibility at the local level to do things that we see are needed to be done in our States.

I would like to lay to rest one thing I have heard. I saw it in the Blue Sheet the other day. This may not be popular with HEW, but I am not concerned about that. I am not popular with a lot of people.

I would like to lay to rest the allegation that States do not properly account for block grant money. The real problem lies, not with the States, but with HEW. We account for every dime. It is much easier for a Federal person to develop standards for accountability in a categorical program. That is relatively simple. But you require a fairly broad perception and knowledge of programs in a wide spectrum of activities for accountability on a block grant program. It is a most flexible and dynamic type of program. We still need categorical programs but we certainly need the block grant which has gone backwards as far as a stable level of support is concerned.

I have nothing further to say.

If you have any questions, fine.

Senator KENNEDY. Do you support performance standards?

Dr. CANNON. Yes, sir. We use them all the time.

Senator KENNEDY. We are able to at least do an evaluation of what is happening in various States and what kind of performance?

Dr. CANNON. As was mentioned earlier, there is a quite detailed report on this that was done through the National Public Health Program Reporting System. We are able to account for what we get from the Federal Government and how it is expended.

Senator KENNEDY. And how effective it is, at least an evaluation of how effective it is?

Dr. CANNON. Yes, sir. We think we can in our block grant program. There are those who think we cannot. I do not necessarily agree with them. All wisdom does not lie in HEW.

Senator KENNEDY. What is your view about inclusion? I think Dr. Whalen mentioned the inclusion of preventive health care programs within this section.

Dr. CANNON. Just to highlight a couple of things. Home health care, we think we can do, and we have some good things going in Rhode Island. We think with the use of a little block grant money, and there are salaries involved in this, but all those salaries provide services—well, handgun education.

We had a doctor killed by a patient. We have been trying to get things going and we think that we can. Some of this money could fund a sensible, intelligent handgun control program in Rhode Island. That is the type of thing we want to use block grant money for. There are other things, life styles.

Senator KENNEDY. Dr. Word.

Dr. WORD. Mr. Chairman, I was not prepared to make a statement. But in light of some of the discussions, there are a couple of statements I would like to make for the record.

First of all, I would like to direct your attention in the material that you will receive that we have documented that $1.5 billion is spent by State and local governments in the provision of basic public health services. We can give you a list of those services. We have found there are some 60 public health services that are common to all 50 States; $1.5 billion was spent by State and local governments for provision of basic public health services. The Federal Government shares in that to the tune of $90 million.

When you define the $90 million you get under 314(d), $15 million of that goes to mental health. There is about $75 million that goes into the kinds of services we are talking about. And roughly calculating, that is about 5 to 6 percent.

Now, the proposal that we are discussing has been introduced by Senator Chafee and it is the proposal where the Federal Government would cost share with States and localities. For example, the first year the program would cost, with a floor of $1, that is minimum of $1 per capita. It would cost the Federal Government about $225 million, going up to about $300 million the third year.

So what we are asking you to do is not to block grant dollars to State and local health departments, we are asking you to cost share with us. We spend $1.5 billion at the local and State government level. The Federal Government has spent $75 million. We would like

you to enhance that partnership by sharing at the level of 10 percent the first year; 15 percent the second year, and 20 percent the third year; going from a level of $225 million to a maximum of about $300 million, which is roughly $1.50 per capita.

Thank you.

Senator KENNEDY. Dr. Wallace.

Dr. WALLACE. It is a pleasure to be here, sir. I very warmly endorse the remarks of Drs. Whalen and Cannon, and Mr. Word.

We have a real bind on funding in our county. We feel funding proposals would especially help us. My goal is more community support services. I would love to provide more occupational therapists, more physical therapists, audiologists, nutritionists, social workers. These personnel would go into programs such as home health, community outreach and even small medical clinics serving underserved areas of Prince George's County. We need more money.

Senator CHAFEE. I cannot hear you very well. Speak into the microphone please.

Dr. WALLACE. We do have a bind. We are developing a health care system in the county that gobbles up Federal, State, and local dollars. The Health Department does need more help and more funding.

Senator CHAFEE. I agree wholeheartedly with what these gentlemen are saying. I would like to express our appreciation for them coming down. I know personally the work Dr. Cannon has done. He testified before Paul Rogers' committee when I was in the State House in an attempt to get a whole block grant concept. It is one of these things that has worked out well.

As they testified, it has not kept pace in funding due to erosion of inflation. I think they make a very good point. It is preventive medicine concept.

Thank you for coming.

Senator JAVITS. Mr. Chairman, I, too, would like to thank Dr. Whalen of my own State. I have been unbelievably engaged this morning, including the Panama Canal treaty and the SALT treaty and everything else and I have had Dr. Whalen's testimony monitored. I appreciate the testimony very much and will study it very carefully.

Senator KENNEDY. Senator Pell.

Senator PELL. I am very glad to see Dr. Cannon here. I enjoyed working so much with him for over 18 years now.

Dr. CANNON. I do not know who came first, you or me—about the same time.

Senator PELL. Our hair is about the same color anyway.

My rule of thumb for Rhode Island is that in any Federal program that gives us about half of 1 percent of the total appropriations, we do pretty well, and if we get less, we do not get our proportionate share. If we get more, we do better. I am a little worried about the whole concept of block grants and what makes you think the other 99½ percent of the money that we do not get will be spent as well as it is in Rhode Island? I have complete faith in your spending. If we enlarge this from 100 million roughly to 500 million——

Dr. CANNON. Well, I have a very quick answer to that, Senator. I think that we feel that the State Health Officers, and there are some good ones, are not all stupid. We do a reasonably good job. I think there are some which I would not want to mention that do not do as good a job.

Senator PELL. Pull the microphone a little closer.

Dr. CANNON. I have been impressed with what most State health directors I have known over the years have done. I think they use this money wisely. I would not say that all of them have used it as well as it should be used. I think that this is true of almost every program.

Senator PELL. Is it not correct to say there are only two States that have statewide health systems, or are there more?

Dr. CANNON. Yes, sir. But even Delaware is not quite as complete as we are.

Senator PELL. There are no others?

Dr. CANNON. No. They mention Hawaii as similar but they really function on a litttle different basis.

Senator PELL. Thank you very much.

Senator KENNEDY. I just want to say that my concerns about whether it is in this program or in the child and maternal health program we discussed earlier, I think one of the real failures of the Congress is the failure to get accountability in many of these programs, and to do the kind of evaluation. And I think if we are going to talk about an important increase in expansion, I think we have to be very, very sure how these resources are being expended and whether they are really meeting what I think Senator Chafee rightfully pointed out, the whole important area of preventive health care, whether this is really the best instrument to do it. I think as far as I am concerned that is why I want to have an answer and a chance to see what the record has been, and what is happening today.

Very frankly, I think in terms of my own State it has been a very mixed bag.

Senator CHAFEE. You mean the block grant concept?

Senator KENNEDY. Block grant concept. In terms of how those funds have come into the state, whether they have been identified as special funds that should be used in terms of developing new alternative ways, of both delivery and preventive health care and special kind of health care needs. And it has been a very mixed bag. I think that is probably being somewhat charitable to it.

I just want to make sure myself as we consider the kind of expansion on this, that we are at least going to be sure that we are not just augmenting or supplementing, you know, general funds in States, but they are being targeted in what I think all of us very well agree is an important purpose, preventive health care, and new and innovative ways.

Senator CHAFEE. I would like to say this, that I agree with you that these programs should be appraised. However, I think it is important to bear in mind this program has been level funded in actual dollars for 11 years. In effect, it is cut in half. Therefore, the chance for innovative programs in this particular area has been extremely limited, and you are lucky if you can continue to maintain what you

have done. Once you get into these home care programs, somebody has to carry them on. Maybe the States should step up and carry it on, and the block grant money should move on to something else. Even in categorical grants you have steady maintenance of programs; you do not necessarily get innovation, whether it is heart care or tuberculosis or whatever it might be.

Senator PELL. Mr. Chairman, I would hope the two different approaches could be molded together. What it really boils down to is a question of policy and cost. One is more costly than the other and has fewer regulatory constraints.

As Senator Chafee points out, if you look at it from the viewpoint of inflation it has been level funded and the other question is whether there should be far fewer regulations or guidelines that there are now, and perhaps one could compromise there because there could be too many guidelines now, and I think they should be used in general ways—I see some of these thoughts as to how money would be spent, which Dr. Cannon advanced. Maybe we could have somewhere in between.

Senator KENNEDY. But we want to thank you very much. We will work closely with you and appreciate very much your presence here.

Dr. WHALEN. We appreciate the opportunity to come.

[The prepared statement of Dr. Whalen follows:]

STATEMENT OF

ROBERT P. WHALEN, M.D.
COMMISSIONER
NEW YORK STATE DEPARTMENT OF HEALTH

REPRESENTING
ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS

BEFORE THE
SENATE SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH

RE: S.2474

MARCH 1, 1978

28-386 O - 78 - 21

Mister Chairman, members of the Subcommittee, I am Doctor Robert P. Whalen, Commissioner of the New York State Department of Health. In my presence before you today, I represent the Association of State and Territorial Health Officials, also known as ASTHO.

Senator Kennedy, let me begin by thanking you and your colleagues for the wisdom and support which brought the Partnership in Health Program into being eleven years ago. Through your foresight, you helped to establish the common responsibility of government on all levels -- federal, state and local -- to work together to pursue initiatives to improve and protect the health of the American people. We believe the health advances of the past decade bear eloquent witness to the value of federal block grants for community and state public and preventive health programs.

Partly as a result of these advances, an infant born today in the United States has an average life expectancy of 73 years; our infant mortality rate is the lowest in the nation's history; and in the past 14 years, we have seen a 25 percent decline in rate of death from our number one killer, coronary artery disease. Since 1900, there has been an age-adjusted 61 percent reduction in our nation's overall death rate.

Much of the credit for these advances belongs to our public health departments, who have carried out relentless -- and often unduplicated -- campaigns to protect the people's health and prevent sickness and death.

It is on the basis of this record that we State Health Officials believe the time has come to enlarge our efforts in the fields of disease prevention and health protection. In short, we believe it is time that we matched our health rhetoric with dollars, and time that the states were more equal partners in the federal-state health partnership.

Fifty or one hundred years from now, if an historian were to look back at our current health spending policy, I suspect he or she would come to the conclusion that we were unable to tell the difference between sickness and health. For, in our zeal to treat sickness, and to pay for the cost of this treatment, there exists the clear and imminent danger of ignoring our essential objective -- the achievement of optimum health and well-being through the prevention of illness.

Last year, the federal government spent over $45 billion on health, by far the greatest share of it on sickness treatment. Yet, the Federal investment in basic health preventive and protective services is at low ebb, standing at less than 50 cents per person yearly, out of a total government health outlay of some $270 per person, per year.

In the light of these sobering economic data, the Association of State and Territorial Health Officials recommends the enactment of legislation to provide for a national health protection system, one that will generate a new health incentive plan for the all of our states and all of the American people.

Senator Chafee has introduced S.2567 to do precisely this, and we warmly endorse his bill. Its principal economic impact would be to increase federal spending for health protection from the current level of less than 50 cents per person to a maximum per capita outlay of $1.50 yearly.

I come before you today to say, unless we are prepared to make such an investment in our public health departments, their valuable potential may be lost.

Federal Partnership for Health spending under Section 314d now stands at $90 million annually, which represents less than five percent of the total local, state and federal funds expended on health programs covered under 314d. Thus, the federal government is not acting as a partner with the states in the field of health protection, it is acting as a minority stockholder. What we have is a situation in which there are no incentives to state or local governments to increase health spending because there is no federal matching arrangement to encourage them to do so.

Without such incentives, distinguished Senators, I can assure you that the states will not be in a position to address their most serious public health problems and needs.

Let me cite several examples of what I mean.

I daresay every state in the nation is confronted with the problem of environmental contamination by industrial chemicals and wastes. Yet, for want of funds, the whole field of environmental toxicology is in its infancy. We simply do not have, without additional federal help, the resources and personnel to monitor these chemicals, take steps to prevent their discharge, and assay their hazard to man.

In my home state of New York, these environmental health perils take the form of PCBs that foul the sediment of the Hudson River from 200 miles inland to the sea, trichlorethylene and other potential carcinogens in the drinking water wells of a number of Long Island communities, mirex and other toxic pesticides in fish in Lake Ontario, and God knows how many other industrial contaminants we haven't as yet discovered.

We States must have more federal help if we are to seek out these insidious invaders of man and his environment, discover their long-term effects in humans, and purge them or prevent their discharge. Doing this will require skilled scientific personnel, sophisticated equipment and -- most of all -- money.

For indeed, the unseen health enemies we face today are not the communicable diseases and natural parasites of years gone by, but the environmental parasites that contaminate our drinking waters, our fisheries and farmlands, and, for too many Americans, our places of work.

There are many other health initiatives, besides toxicology, that we will be unable to pursue without a balanced and expanded federal-state health partnership.

For example, a number of states are carrying out pilot programs which are proving remarkably effective in detecting and treating the most ubiquitous of American diseases: high blood pressure. These programs, which find and control high blood pressure before it can lead to a more disabling illness and costly hospitalization, have a tremendous health potential, since hypertension strikes an estimated one in ten Americans. We need to make these preventive advances available to all of our citizens.

What motivates an individual to stop smoking, curtail drinking, adopt a better diet and a saner lifestyle? We must learn more about human motivation, but one thing is clear: health education, particularly the kind that is aimed at schoolchildren during their formative years, is one of the best investments government can make, because it promises a whole lifetime of healthy practices.

We need more personnel, particularly public health nurses, to increase our home health care capability and thereby cut down on unnecessary utilization of expensive hospitals and nursing homes.

And the often crushing and crushingly expensive tragedy of birth defects can many times be prevented or ameliorated with the kind of aggressive screening programs some states have adopted, and other states would adopt, were there federal encouragement to do so.

We States, with your help, can increase our commitment to these and other programs, which are vital to the health of the American people. But we cannot do so unless the Congress approves a higher level of aid to the States for their community-based programs of disease prevention and control.

We certainly cannot address our most pressing health challenges if each year we must sweat through a one-year extension of the 314d program. This is no partnership, nor does it permit forward planning for health. Indeed, there can be no partnership when one of the principals is being slowly starved, in the sense that federal participation in this program has stood still since 1967, a period of time in which inflation alone has virtually doubled costs.

So, Mr. Chairman, and members of the Subcommittee, the time has come to ask ourselves whether we really believe that, in terms of the people's health, an ounce of prevention is worth a pound of cure. If we do believe in the wisdom of that ancient saying, then we must move forward to new horizons in the federal-state health partnership. And we must do so now, so that organized community disease prevention programs can be a part of the foundation on which we build a program of National Health Insurance.

I thank you for giving ASTHO this opportunity to be heard on this important matter. I will gladly entertain your questions.

Senator KENNEDY. Next we will have a panel on Genetic Diseases, Dr. Leon Rosenberg, chairman, Department of Genetics, Yale University; Dr. Robert Murray, chief, Division of Medical Genetics, Howard University; Mrs. Joan Marks, director, Genetic Associates Program, Sarah Lawrence College; and Mrs. Marjorie Guthrie, president-emeritus, Committee to Combat Huntington's Disease.

Senator Javits?

Senator JAVITS. On Monday, February 27, I introduced along with 18 of my colleagues, the National Genetic Diseases Act Amendments of 1978. I was the author of the original legislation, enacted as title IV of Public Law 94–278 in 1976, the National Sickle Cell Anemia, Tay-Sachs, and Genetic Diseases Act. This legislation provides for the national program of basic and applied research, health services, such as testimony and counseling for the diagnosis, control and treatment of genetic diseases; and information and education programs with respect to such diseases. The program was funded for the first time in fiscal year 1978 at $4 million.

The bill we have introduced would reauthorize the Genetic Diseases Act for 3 more years at the same authorization level of $30 million. In addition, the bill expands, strengthens and improves the existing legislating, insuring that it carries out the original legislative intent. It provides for planning based on local need for specific genetic services as well as program evaluation through appropriate peer review. It requires new, noncategorical initiatives in genetics research and services for all genetic diseases, and reemphasizes the generic intent of the legislation to include all genetic disorders. Much of the activity specified in the act will involve the State and local health departments, but allocation of Federal funds to these organizations should be only one mechanism by which programs are implemented. The bill provides flexibility of funding to allow mechanisms for funding local programs as well as demonstration and pilot programs of merit.

The bill requires the Secretary to develop a procedure whereby consumers and professional genetic disease experts are authorized to make program recommendations, and to advise on a wide range of interdisciplinary issues involving research, detection, prevention and treatment of genetic diseases. A study is authorized to be conducted by the National Commission for the Protection of Human Subjects on the ethical and legal implications of genetic screening, counseling and education services.

More than 2,300 genetic diseases have been described to date—and the list is growing rapidly. About 30 percent of hospitalized children have diseases of genetic origin, 40 percent of all infant mortality results from genetic factors, and 80 percent of all mental retardation in this country is genetically related. Many forms of blindness, deafness, and crippling disorders are passed from generation to generation. Furthermore, genetic components are strongly implicated in some of man's most common afflictions, such as diabetes, high blood pressure, schizophrenia, heart disease, and some forms of cancer.

I want to stress one signal fact, inherited diseases are, above all, family diseases which impact overwhelmingly on the well-being and integrity of the family. Diseases which are passed from parent to child

may strike multiple members of a family simultaneously, inflicting a unique and terrible burden. Evidence shows that the divorce rate in families where a genetic defect has been discovered is four times higher than among the general public. Access to psychological and psychiatric counseling and support is invaluable in helping to cope with the psychological stress of acute physical illness—a stress which in itself could be life threatening.

Another important fact that cannot be stressed too strongly is that genetic diseases are chronic diseases. Many of these conditions manifest themselves at birth, and most last through life, often placing patients and families under severe financial strains which can grind them to poverty.

But hereditary disorders have a unique feature in that often they are susceptible to early detection and treatment. Today, 60 genetic disorders can be detected before birth; more than 60 metabolic diseases are amenable to treatment; carrier tests are available for 60 diseases which can identify the healthy individual who may be carrying a defective gene that would produce disease in future offspring.

Contrast the economics when preventive genetic medicine is involved. A more common genetic disease, which occurs about once in every 14,000 births is called PKU. This is disorder, if undetected, produces severe mental retardation caused by an error in metabolism. It costs $1.25 to screen a newborn baby for PKU. If the disorder is diagnose through screening tests at birth and treated immediately with a special dietary regimen, these children will grow up to lead normal lives. If undetected and untreated, a PKU victim would most likely spend a lifetime in an institution at a cost of more than a quarter of a million dollars. Yet even such cogent economic arguments pale when we consider the lifetime of sorrow and burden these families are spared.

It is not possible to measure the emotional trauma and tragic uncertainty facing families with hereditary disease. When we possess the tools and the medical knowledge to prevent and treat diseases which are so devastating, how can we continue to tolerate such pain and cost and human suffering?

It is therefore imperative that all people in need have access to genetic services, which should be integrated into primary health care.

Finally, I would like to make an important comment. This bill establishes a voluntary program for screening, testing, counseling and information. I believe that each of us has the right to as much information as medicine can provide—information concerning disease, the pattern of transmission of hereditary disease, of the risks of recurrence, and the consequences of the disease in practical terms for everyday living, including financial burdens. There is some mystery still associated with medicine, but there is also a great deal of knowledge. With this information, "informed choice" is possible; that is, each person may make a value decision confident of the fact that he or she has all the information possible. To withhold medical knowledge which could prevent crippling and death is unfair and unjust. To withdraw from seeking that information is to proceed in a vacuum, without the benefit and the right to our own value decisions.

As infectious diseases are brought increasingly under control, genetic disorders are becoming a leading contributor to the Nation's mor-

bidity rates. The provisions of this bill will strengthen and improve the national program of genetic disease services provided in the National Genetic Diseases Act.

I want to thank the panel very much for appearing.

Could we ask the members of the panel to sum up their remarks in about 5 minutes each?

Dr. Rosenburg, if you feel that you need it, we will let you take 10 minutes, and each of the others 5.

STATEMENTS OF DR. LEON E. ROSENBERG, CHAIRMAN, DEPARTMENT OF HUMAN GENETICS, YALE UNIVERSITY; DR. ROBERT F. MURRAY, CHIEF, DIVISION OF MEDICAL GENETICS, HOWARD UNIVERSITY; MRS. JOAN H. MARKS, DIRECTOR, GENETIC ASSOCIATES PROGRAM, SARAH LAWRENCE COLLEGE; AND MRS. MARJORIE GUTHRIE, PRESIDENT-EMERITUS, COMMITTEE TO COMBAT HUNTINGTON'S DISEASE, A PANEL

Dr. Rosenberg. My name is Dr. Leon E. Rosenberg. I am a professor of Human Genetics, Medicine and Pediatrics, and chairman of the Department of Human Genetics at the Yale University School of Medicine. I am also the director of Yale's NIH-sponsored Center for Human Genetics and Inherited Diseases. For nearly 20 years, I have studied genetic diseases at the bedside and at the laboratory bench, and have witnessed the enormous growth in our understanding of both normal genetic mechanisms and those abnormal ones which cause disease. During this same interval, I have cared for scores of patients and families each afflicted with, or at risk for a genetic disorder. This experience has convinced me that, as a Nation, we have been far more resourceful in acquiring knowledge about genetic diseases than in applying that knowledge to the care of sick people. For this reason I believe Public Law 94–278 is an historic piece of legislation and I urge its extension and its full appropriation.

I feel certain that I need not remind this committee that genetic disorders are the most widespread and among the most burdensome of known afflictions, that they affect approximately 6 percent of our citizens, or that they are responsible for 30 percent of childhood hospitalizations, for 40 percent of infant mortality, and for nearly 80 percent of mental retardation. Inasmuch as recitation of this litanty underscores the global impact of genetic disease, I mention it. However, neither compilation of such health statistics nor enumeration of the hundreds of known genetic disorders provides a sufficient rationale for the expenditure of Federal funds for the support of genetic health services. I prefer to justify such expenditures in terms of specific strategies for specific disorders.

To me, genetic health services means screening of newborns for phenylketonuria because early diagnosis and appropriate dietary management can prevent the severe mental retardation which occurs regularly in the untreated patient. Genetic health services means testing of black infants for sickle cell anemia because such detection, followed by appropriate immunization or antibiotic programs, can forestall the often lethal bacterial infections to which these children are predisposed. Genetic health services means the regular, prophy-

lactic administration of antihemophilic factor to children and adults with hemophilia because such costly but effective treatment will prevent the crippling consequences of this disease. Genetic health services means testing of Jewish teenagers for the Tay-Sachs gene because individuals and couples who carry this trait have a right to make informed marital and procreational decisions based on this information. Genetic health services means counseling the relatives of patients with Huntington's disease because some of these individuals are at risk for the disease and must bear that burden, whereas others are not at risk and are entitled to that relief.

In theory, genetic health services should be far less expensive and easier to organize than many others for, after all, they are based on sound predictive principles and are aimed at prevention of disease. In practice, however, they are currently very difficult to deliver because neither the public nor the medical profession understands adequately the principles upon which genetic medicine is based, and because our health care system is much more oriented to crisis intervention than disease prevention.

Preventing coronary artery disease in genetically susceptible individuals by long-term restriction of dietary fats, and cholesterol has none of the glamor of by-pass graft heart surgery. Preventing pulmonary emphysema by advising genetically predisposed individuals to avoid cigarette smoking and other noxious inhalants has none of the drama of emergency ventilatory assistance. It is at cruel paradox that we are willing to pay infinitely more for treating disease than we are for maintaining health. This posture has a particularly deleterious effect on the provisions of genetic health services. Despite their obvious human benefits and demonstrated cost effectiveness, most third party payers refuse to consider genetic screening, diagnostic amniocentesis, and genetic counseling reimbursable expenses.

This unfortunate state of affairs must be remedied. Until it is, other funding approaches must bear an even greater burden. In fact, the need for Federal funds to support the teams of physicians, paramedical associates, nurses and social workers required to deliver high quality genetic services is greater now than ever. In the past, grants from the National Foundation-March of Dimes were a major source of support for personnel engaged in providing diagnostic, therapeutic and counseling services for genetic disease. The very recent decision of the foundation to direct its clinical support funds elsewhere has created a huge and critical gap which only the Federal and State governments can fill.

In conclusion, I believe the time has come for the truths of genetic research to be translated more effectively into well organized, humane, clinical programs. Those of us at university medical centers, research institutes, and State health departments must begin to make what we do commensurate with what we know.

The 1978 amendments to the National Genetic Diseases Act clarify the intent of this bill to provide comprehensive genetic services as part of primary health care for all persons needing such services. The funds authorized in this bill will, if appropriated, speed us toward that goal.

Thank you.

[The prepared statement of Dr. Rosenberg follows:]

March 1, 1978
L. E. Rosenberg

TESTIMONY AT PUBLIC HEARING REGARDING EXTENSION OF AND AMENDMENTS TO PL94-278

My name is Dr. Leon E. Rosenberg. I am a professor of Human Genetics, Medicine and Pediatrics and Chairman of the Department of Human Genetics at the Yale University School of Medicine. I am also the director of Yale's NIH-sponsored Center for Human Genetics and Inherited Diseases. For nearly 20 years, I have studied genetic diseases at the bedside and at the laboratory bench, and have witnessed the enormous growth in our understanding of both normal genetic mechanisms and those abnormal ones which cause disease. During this same interval, I have cared for scores of patients and families each afflicted with, or at risk for a genetic disorder. This experience has convinced me that, as a nation, we have been far more resourceful in acquiring knowledge about genetic diseases than in applying that knowledge to the care of sick people. For this reason I believe PL94-278 is an historic piece of legislation and I urge its extension, and its full appropriation.

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federal funds for the support of genetic health services. I prefer to justify such expenditures in terms of specific strategies for specific disorders.

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prevention. Preventing coronary artery disease in genetically susceptible individuals by long-term restriction of dietary fats and cholesterol has none of the glamor of "by-pass" graft heart surgery. Preventing pulmonary emphysema by advising genetically predisposed individuals to avoid cigarette smoking and other noxious inhalants has none of the drama of emergency ventilatory assistance. It is a cruel paradox that we are willing to pay infinitely more for treating disease than we are for maintaining health. This posture has a particularly deleterious effect on the provision of genetic health services. Despite their obvious human benefits and demonstrated cost effectiveness, most third party payers refuse to consider genetic screening, diagnostic amniocentesis, and genetic counselling reimbursable expenses. This unfortunate state of affairs must be remedied. Until it is, other funding approaches must bear an even greater burden. In fact, the need for federal funds to support the teams of physicians, paramedical associates, nurses and social workers required to deliver high quality genetic services is greater now than ever. In the past, grants from the National Foundation-March of Dimes were a major source of support for personnel engaged in providing diagnostic, therapeutic and counselling services for genetic disease. The very recent decision of the Foundation to direct its clinical support funds elsewhere has created a huge and critical gap which only the federal and state governments can fill.

In conclusion, I believe the time has come for the truths of genetic research to be translated more effectively into well organized, humane, clinical programs. Those of us at university medical centers, research institutes, and state health departments must begin to make what we do commensurate with what we know. The funds authorized in this bill will, if appropriated, speed us toward that goal.

Senator JAVITS. Thank you very much, Dr. Rosenberg.

Dr. Murray, would you follow?

Dr. MURRAY. Mr. Chairman, Senators, ladies and gentlemen, my name is Robert F. Murray, Jr. I am a professor of pediatrics and medicine in the College of Medicine, graduate professor of genetics and human genetics in the Graduate School of Arts and Sciences, chief, Division of Medical Genetics, Department of Pediatrics and Child Health of Howard University. I also direct the Genetic Counseling Division of the Center for Sickle Cell Disease, Howard University. In addition, I am a Fellow and member of the Board of Directors of the Institute of Society, Ethics and the Life Sciences, the Hastings Center. I have recently been appointed a member of the Bioethics Advisory Board to the Secretary of Health, Education, and Welfare.

I am speaking in support of the renewal of Public Law 94–278, title IV, The National Sickle Cell Anemia, Cooley's Anemia, Tay-Sachs and Genetic Diseases Act. There are three points that I want to speak to.

1. This bill should be passed because it is important to provide continuous support for the programs of education, screening and counseling for genetic diseases where they are already well established and are beginning to have a significant effect on people who are at increased risk to inherit a genetically determined disease. This is particularly important where these programs have not been yet integrated into the general health care delivery system of the community. In this context, it is especially vital that the effective, comprehensive sickle cell centers and sickle cell screening and education clinics should be continued. In similar fashion, other well established or newly emerging programs that are delivering effective genetic services should be given priority in awarding grants and contracts at least until they can be made self-supporting or else become a part of the health care system. If the already existing programs have been effective, it should be possible to add the capability for screening for other diseases which should be less expensive than starting new programs from scratch.

2. It is important to pay attention to the ethical and moral conflicts that can arise when programs of genetic service are established on a large scale, especially in communities that are not prepared for them.

It might be cost effective to do genetic screening in a population that is easy to get at, for example children entering nursery school, but a properly performed screening program is certain to uncover instances of nonpaternity. Here the child's need for a stable family is threatened by the right of the father to the information from the genetic tests. Should the counselor violate the ethical principle of truth telling in order to preserve the family and the mother's integrity? Which takes precedence, the obligation of the screener to the person being screened or to the State which may be financing the screening program? Should the genetic counselor's prime obligation be to the parents or the unborn fetus or to the State's interest in reducing the burden of genetic disease? Where screening tests identify couples at high risk to have children with genetically determined disease, how should their obligations be ranked? Does their right to

procreate and be parents of children who may be genetically handicapped supersede their obligation to society and the human gene pool not to give birth to genetically abnormal children? Is the right to be born free of genetic defect valid in an ethical sense? Is the information obtained in genetic testing subject to the same rules of confidentiality as other medical information or is genetic information more properly the property of genetic or blood relatives?

This means that results of genetic testing can be shared with them without the permission of the person tested. The provision in this bill recommending that the National Commission for the Protection of Human Subjects be continued and that it review the ethical implications of programs of education, screening and counseling for genetic disease clearly recognizes the need for a detailed study of these and other profound ethical and legal questions that are raised by the programs that would be promulgated by this bill.

3. I served as a member of the Committee for the study of Inborn Errors of Metabolism, a working group of the National Research Council of the National Academy of Sciences. In 1975, after 2 years of intensive study, this committee issued a report, "Genetic Screening, Programs, Principles and Research." One of the major recommendations of this report sets forth a series of conditions which should guide the development of new genetic screening programs. A key step recommended by this group in the development of new programs is a pilot study or field trial. This will serve not only to help identify technical and procedural difficulties but should help surface previously unsuspected legal, psychosocial, and ethical conflicts that might cause harm to individuals or to entire communities.

An example of this harm is the unexpected stigmatization, not only of patients with the disease, but also persons who are otherwise healthy carriers of the sickle-cell gene. If one or more pilot programs in education, screening, and counseling for sickle-cell disease had been carried out before launching the large-scale program, it is probable that some of the negative effects of the early sickle-cell screening programs might have been avoided or, at the very least, have been minimized. Some of the danger that was done by poorly conceived and ill-advised educational programs and screening without counseling is still being repaired by the ongoing sickle-cell centers and screening and counseling clinics.

Providing funds for planning will make it possible for qualified professionals to set up new screening programs for genetic diseases or their carrier states as the technology for genetic testing is improved and refined. Part of the planning strategy should involve setting up pilot programs to make certain that flaws in program design are found early and tha members of the community are ready to participate in the program to maximize the likelihood that its net impact will be positive.

Even though there are certain principles that are common to all genetic disorders, each of them has its own peculiarity. Furthermore, the same genetic disease can be responsible for different ethical and psychosocial problems in different ethnic or religious groups.

There is a definite and growing need and desire for the genetic services that will be provided by this bill. More than 70 percent of

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a sample of 5,000 small-college students who were surveyed about ethics and genetic disease, felt that it was important to know what abnormal genes they carried. A similar proportion felt that genetic screening and counseling services were needed. To provide continuity in existing genetic services, to provide for the most humane, beneficial, and also practical introduction of new genetic services and the expansion of existing ones to meet the growing desire and need for these services, I recommend that the committee approve this bill.

Senator JAVITS. Thank you so much.

[The prepared statement of Dr. Murray follows:]

Testimony before the Senate Subcommittee on Health of Robert F. Murray, Jr., M.D. on renewal of P.L. 94-278, Title IV

March 1, 1978

Mr. Chairman, Senators, Ladies and Gentlemen, my name is Robert F. Murray, Jr., M.D., M.S., F.A.C.P. I am Professor of Pediatrics and Medicine in the College of Medicine, Graduate Professor of Genetics and Human Genetics in the Graduate School of Arts and Sciences, Chief, Division of Medical Genetics, Department of Pediatrics and Child Health of Howard University. I also direct the Genetic Counseling Division of the Center for Sickle Cell Disease, Howard University. In addition, I am a Fellow and member of the Board of Directors of the Institute of Society, Ethics and the Life Sciences, the Hastings Center. I have recently been appointed a member of the Bio-ethics Advisory Board to the Secretary of Health, Education and Welfare.

I am speaking in support of the renewal of P.L. 94-278, Title IV, The National Sickle Cell Anemia, Cooley's Anemia, Tay Sachs and Genetic Diseases Act. There are three points that I want to speak to.

1. This bill should be passed because it is important to provide continuous support for the programs of education, screening and counseling for genetic diseases where they are already well established and are beginning to have a significant effect on people who are at increased risk to inherit a genetically determined disease. This is particularly important where these programs haven't yet been integrated into the general health care delivery system of the community. In this context, it is especially vital that the effective, comprehensive sickle cell centers and sickle cell screening and education clinics should be continued. In similar fashion, other well established or newly emerging programs that are

delivering effective genetic services should be given priority in awarding grants and contracts at least until they can be made self supporting or else become a part of the health care system. If the already existing programs have been effective, it should be possible to add the capability for screening for other diseases which should be less expensive than starting new programs from scratch.

2. It is important to pay attention to the ethical and moral conflicts that can arise when programs of genetic service are established on a large scale, especially in communities that aren't prepared for them.

It might be cost effective to do genetic screening in a population that is easy to get at, for example children entering primary school, but a properly performed screening program is certain to uncover instances of non-paternity. Here the child's need for a stable family is threatened by the right of the father to the information from the genetic tests. Should the counselor violate the ethical principle of truth telling in order to preserve the family and the mother's integrity? Which takes precedence, the obligation of the screener to the person being screened or to the state which may be financing the screening program? Should the genetic counselor's prime obligation be to the parents or the unborn fetus or to the state's interest in reducing the burden of genetic disease. Where screening tests identify couples at high risk to have children with genetically determined disease

how should their obligations be ranked? Does their right to procreate and be parents of children who may be genetically handicapped supercede their obligation to society and the human gene pool not to give birth to genetically abnormal children? Is the right to be born free of genetic defect valid in an ethical sense? Is the information obtained in genetic testing subject to the same rules of confidentiality as other medical information or is genetic information more properly the property of genetic or blood relatives? This means that results of genetic testing can be shared with them without the permission of the person tested. The provision in this bill recommending that the National Commission for the Protection of Human Subjects be continued and that it review the ethical implications of programs of education, screening and counseling for genetic disease clearly recognizes the need for a detailed study of these and other profound ethical and legal questions that are raised by the programs that would be promulgated by this bill.

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step recommended by this group in the development of new programs is a pilot study or field trial. This will serve not only to help identify technical and procedural difficulties but should help surface previously unsuspected legal, psychosocial and ethical conflicts that might cause harm to individuals or to entire communities. An example of this harm is the unexpected stigmatization, not only of patients with the disease, but also persons who are otherwise healthy carriers of the sickle cell gene. If one or more pilot programs in education, screening and counseling for sickle cell disease had been carried out before launching the large scale programs, it is probable that some of the negative effects of the early sickle cell screening programs might have been avoided or at the very least, have been minimized. Some of the damage that was done by poorly conceived and ill-advised educational programs and screening without counseling is still being repaired by the ongoing sickle cell centers and screening and counseling clinics.

Providing funds for planning will make it possible for qualified professionals to set up new screening programs for genetic diseases or their carrier states as the technology for genetic testing is improved and refined. Part of the planning strategy should involve setting up pilot programs to make certain that flaws in program design are found early and that

members of the community are ready to participate in the program to maximize the likelihood that its net impact will be positive.

Even though there are certain principles that are common to all genetic disorders, each of them has its own peculiarity. Furthermore, the same genetic disease can be responsible for different ethical and psychosocial problems in different ethnic or religious groups.

There is a definite and growing need and desire for the genetic services that will be provided by this bill. More than 70% of a sample of 5,000 small college students who were surveyed about ethics and genetic disease felt that it was important to know what abnormal genes they carried. A similar proportion felt that genetic screening and counseling services were needed. To provide continuity in existing genetic services, to provide for the most humane, beneficial and also practical introduction of new genetic services and the expansion of existing ones to meet the growing desire and need for these services, I recommend that the committee pass this bill.

THANK YOU!!

Senator JAVITS. Mrs. Marks, would you proceed?

Mrs. MARKS. I am Joan Marks, director of the human genetic program at Sarah Lawrence College in Bronxville, N.Y. I am grateful to the committee for this opportunity to speak to the need for a national commitment to train all levels of health professionals to recognize the role that genetics plays in human disease. The 20 million Americans who suffer the results of genetic disease and the countless Americans who may be at risk for genetic disease themselves or in their offspring, have a well-established need for a more intensive effort from the biomedical community to understand and, through understanding, improve techniques for accurate diagnosis, treatment, and possibly prevention.

But far less recognized is the devastating effect that the presence of genetic disease can have on an entire family. Not only does society at large fail to recognize the impact of this major public health problem, but most health professionals, including physicians, are severely limited in their capacity adequately to care for the millions of people with genetic disease. If one recognizes that as a discipline genetics was not part of the curriculum of the vast majority of today's health practitioners owing to the fact that it has emerged as a substantial discipline only in the last two decades, then it is easier to understand the unfamiliarity of many health professionals with the needs of families and individuals who face the crisis of genetic disease.

In my work as an educator of genetic counselors who are trained to serve as nonphysician members of a genetic counseling team directed by a physician, I have come to a deep appreciation of the widespread lack of knowledge about our current understanding of human genetic disease by health professionals—nurses; doctors, including psychiatrists; lab technicians; psychologists; and social workers. This lack of knowledge among such health professionals, on whom the family in crisis is utterly dependent, greatly increases the burden that genetic disease places on families. Such lack of knowledge is not inevitable by any means and could be markedly altered by an aggressive attempt to educate health-care workers in the fundamentals of human genetics and in the techniques of emotional support which are crucial to maintaining such families at a functional level.

I do not believe that training physicians and other health-care workers in genetics is a matter of quality care versus minimal care. I maintain that the failure to train health professionals in clinical genetics and genetic counseling results in an absence of care for the estimated 20 million Americans subject to the effects of inherited disease. To quote the father of a Down Syndrome, or mongoloid, infant:

> If only our doctor had come and sat down with us to answer our questions and our fears. Instead, we were made to feel this was a situation which couldn't be handled by anyone. One feels that if the professionals can't handle it, then you can't either. I couldn't find anyone to get help from.

Coupled with, perhaps even due to, the need to train professionals to deal with the effects of genetic disease, an organized national effort must be made to educate physicians and other health professionals in the basic principles of clinical genetics and the technology

now available to diagnose, treat, and even prevent genetic disease for those individuals who wish that option. Although most genetic diseases are relatively rare, taken together as a group genetic diseases account for nearly 40 percent of all admissions to children's hospitals. It is estimated that $400 million is spent annually in the United States for the care of patients with Down Syndrome alone. However, a 1974 survey by the National Academy of Sciences of 1,000 Board certified physicians indicated that nearly three-fourths of the doctors reported that they had not had any course work in genetics in medical schools because it was not available. In fact, only half the physicians polled had a reasonable knowledge of genetics. Clearly, other health professionals with less advanced degrees are even less knowledgeable about genetic diseases and, thus, unable to provide appropriate help to those in need.

A physician who does not understand genetic principles and their cardinal feature, predictability, will not only misdiagnose certain disorders in individuals, but will fail to perceive his or her responsibility to the families of such patients who should also be the focus of their care. Approximately 4,000 continuing education courses for physicians were offered during the year 1974–76. Only 16 were given in genetics.

Despite the growing emphasis on preventive medicine, physicians have failed to focus on the potential of genetic medicine. While no survey has been made of continuing education courses in other health disciplines, it seems likely that very few schools in nursing, social work, or public health have a genetic curriculum. More than 90 percent of the physicians polled in the National Academy of Sciences study said they wanted such courses.

At this juncture, as part of an overall strategy for the use of the limited amount of Federal funds available for support of health professional education and health services, a program targeted to provide for effective programs of continuing education in human genetics for physicians and other health professional practitioners deserves a very high priority. I base this recommendation on the service needs as cited by others testifying today, as well as on the data indicating the the widespread lack of knowledge of most health professionals. Such a targeted use of Federal funds could be very effective and should be time limited so as to provide incentives for the development of alternative methods which would, over a 5-year period, phase out the need for a longer period of funding.

In addition to training health professionals, there is a great need to develop new public education materials that are both accurate and sensitive to the implications that genetic disease has for individuals who carry them. An informed public can do much to diminish the impact of this major health care problem.

In summary, I believe Federal funding should be provided to:

One. Develop training programs for health professionals, including continuing education programs for those now in practice, and to strengthen existing programs training physicians and other health professionals, including genetic associates, with the ultimate objective of providing better genetic services commensurate with our present understanding of the tranmission of genetic disease.

Two. Develop an improved national public education program with respect to genetic diseases and their nature and to the possibilities for diagnosis and treatment, as well as for prevention, of genetic diseases for those who wish this choice.

[The prepared statement of Mrs. Marks follows:]

Testimony presented to

The Subcommittee on Health and Scientific Research

March 1,1978

Joan H. Marks
Director
Human Genetics Program
Sarah Lawrence College
Bronxville, New York

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I do not believe that training physicians and other health care workers in genetics is a matter of quality care versus minimal care. I maintain that the failure to train health professionals in clinical genetics and genetic counseling results in an absence of care for the estimated 20 million Americans subject to the effects of inherited disease. To quote the father of a Down Syndrome, or mongoloid, infant:

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physicians indicated that nearly 3/4ths of the doctors reported they had not had any coursework in genetics in medical school because it was not available. In fact, only half the physicians polled had a reasonable knowledge of genetics. Clearly, other health professionals with less advanced degrees are even less knowledgeable about genetic diseases and, thus, unable to provide appropriate help to those in need.

A physician who does not understand genetic principles and their cardinal feature, predictability, will not only misdiagnose certain disorders in individuals, but will fail to perceive his or her responsibility to the families of such patients who should also be the focus of their care. Approximately 4,000 continuing education courses for physicians were offered during the years 1974-1976. Only 16 were given in genetics! Despite the growing emphasis on preventive medicine, physicians have failed to focus on the potential of genetic medicine. While no survey has been made of continuing education courses in other health disciplines, it seems likely that very few schools of nursing, social work, or public health have a genetics curriculum. More than 90% of the physicians polled in the National Academy of Sciences study said they wanted such courses.

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effective and should be time-limited so as to provide incentives for the development of alternative methods which would, over a five year period, phase out the need for a longer period of funding.

In addition to training health professionals, there is a great need to develop new public education materials that are both accurate and sensitive to the implications that genetic disease has for individuals who carry them. An informed public can do much to diminish the impact of this major health care problem.

In summary, I believe federal funding should be provided to:

1. develop training programs for health professionals, including continuing education programs for those now in practice, and to strengthen existing programs training physicians and other health professionals, including genetic associates, with the ultimate objective of providing better genetic services commensurate with our present understanding of the transmission of genetic disease

2. develop an improved national public education program with respect to genetic diseases and their nature and to the possibilities for diagnosis and treatment, as well as for prevention, of genetic diseases for those who wish this choice.

Senator JAVITS. Thank you very much.

Mrs. Guthrie, you have 5 minutes.

Mrs. GUTHRIE. I do not really need a lot of time, Senator. I came unprepared with notes, because I felt I wanted to speak from my heart.

I wanted to tell you I am here as founder and president-emeritus of the Committee to Combat Huntington's Disease, but I would prefer to feel I am here representing any family with any genetic disorder.

Sitting in our audience today I wanted to recognize a colleague, Meg Caulfield, who represents osteogenisis imperfecto and the American Brittle Bone Society. This room could be full, filled with people who have genetic disorders. My feeling is that while professionals have given you their testimony, while they have told you what they think you ought to do, and appreciating your interest in this act, right now there are millions who are suffering with many problems and we need help. We have to have a place to go to and ask what can you do for us while you are working on research, what are you going to do for use who do not know what to tell our children? Where can we get information for the younger generation who could do better than our generation if information and counseling were available!

I am very grateful that you have brought the problem to the fore. We support this act.

We hope that you can convince the other Members of Congress that they must appropriate the $90 million for the full 3 years as originally intended. To give us $4 million for 1 year and then hope that something can be done, makes no sense. We want help that means dollars to provide the services needed—the research needed.

Thank you and please support us.

Senator JAVITS. How very warm and kind of you. How very eloquent. Thank you very much. I wish all my colleagues could hear you. I will do my utmost to transmit your spirit to them. Thank you for bringing so many of your own friends who work hard and are influential into Huntington's Disease effort.

There is one thing I would like to ask all of you. We have no time for questions. If I submit questions in writing, will all the members of the panel be good enough to answer them in writing?

Without objection, they will be included as part of the record. I will ask for your answers 1 week after we submit the questions.

Dr. Murray, I have to ask you one question because an amendment has been introduced on this question.

What is your attitude on mandatory screening as opposed to voluntary screening for which you testified?

Dr. MURRAY. This mandatory screening was one of the provisions that caused so much trouble during the early days of sickle cell disease. Many people felt that their rights were violated and also because certain groups were selected out for such mandatory screening, other groups were excluded. One has a number of problems, not only ethical, but economic, in trying to set up genetic services, when one has a mandatory provision attached to it.

I would say that it would cause more problems than it would solve.

Senator JAVITS. You are opposed to it?

Dr. MURRAY. I am definitely opposed to it.

Senator JAVITS. Dr. Rosenberg, would you care to offer professional opinion on that?

Dr. ROSENBERG. I agree entirely with Dr. Murray.

Senator JAVITS. One last thing.

Dr. Rosenberg, you mentioned in your testimony the fact that the March of Dimes, the National Foundation which has been a supporter of genetic centers has announced plans to redirect their funding. I understand a representative is here in the audience, Mr. Clyde Shorey of the March of Dimes.

Mr. Shorey, I do not want to ask you to be a witness when you have not been called. But would you be kind enough to get for me at my request a letter from the Foundation which will state their policy, their reason for their policy, and what they see will be their policy in the next few years. This will have a material effect on what we do here.

Mr. SHOREY. Yes; Senator, we will certainly do that. We very much support this legislation, and we support continuation of genetic counseling centers. We want to make this very clear to you and to the committee. I will see that you get this letter. I will send, together with a policy statement, will send that to all the members of the committee.

Senator JAVITS. Thank you. That will be fine.

Could we have that, say, within 1 week?

Mr. SHOREY. You will have it right away.

[The following was received for the record:]

28-356 O - 78 - 23

FRANKLIN D. ROOSEVELT, FOUNDER
HARRY E. GREEN, CHAIRMAN OF THE BOARD

THE NATIONAL FOUNDATION
MARCH OF DIMES 1275 MAMARONECK AVENUE, WHITE PLAINS, NEW YORK 10605 ☆ 914 428-7100

CHARLES L. MASSEY
PRESIDENT

March 7, 1978
REC'D MAR 15 1978

The Hon. Jacob Javits
United States Senate
Washington, D.C. 20510

Dear Senator Javits:

In response to your request, directed to Mr. Clyde E. Shorey during the recent hearings of the Subcommittee on Health and Scientific Research of the Senate Committee on Human Resources, I am pleased to send you the enclosed statement setting forth the position of The National Foundation-March of Dimes on the support of genetic service programs.

We are confident that you will continue your role of leadership in creating new federal initiatives to maintain and extend services for patients and families with genetic disorders.

Sincerely yours,

Charles L. Massey

CLM:oz
Enclosure

Statement of Charles L. Massey, President
The National Foundation-March of Dimes
To the Subcommittee on Health and Scientific Research
of the Senate Committee on Human Resources

THE NATIONAL FOUNDATION-MARCH OF DIMES AND GENETIC SERVICES

In response to the request of Senator Javits, I would like to set forth the position of The National Foundation-March of Dimes on the support of genetic service programs. These programs are of major concern to the Foundation and are receiving very substantial financial support from us as part of our overall objective of preventing birth defects and improving the outcome of pregnancy.

Realizing the tremendous importance of genetics research and services to the accomplishment of our goals, we began a number of years ago to make grants to institutions to fund research in genetic diseases and separately to provide the seed money to initiate clinics which would provide genetic services.

We are continuing to make a substantial number of grants for research into the problem of genetics and their causal relationship to some birth defects.

Through the separate program of funding genetic services, which includes screening high risk groups for carriers of certain disorders, diagnosis and treatment of genetic diseases, prenatal diagnosis of some birth defects and counseling for patients and families, the Foundation has helped establish many genetic counseling centers throughout the United States. Currently, 83 of them receive funds from us. The funding of the genetic service programs is only a part of our total medical service program. Grants are also made for neonatal intensive care centers, prenatal and perinatal clinics and similar services in a broad attack to improve the outcome of pregnancy. In 1977 grants for genetic services amounted to approximately $2.5 million out of a total of about $6 million spent for medical service programs.

The philosophy of the Foundation for many years in funding medical service programs has been that the function of a voluntary health agency is to provide initial seed money necessary to demonstrate the need for and value of new services, not to fund established programs in perpetuity. We believe that voluntary agencies can best serve the public by creating innovative demonstrations of needed and effective services and then moving on to new areas of challenge as other problems are lessened or solved. Our policy, established in 1971, is to limit the duration of funding of medical service programs to a maximum of five years.

Many of our currently funded grants for genetic services have met or are approaching the five year limit. Therefore, under our policies and the terms of the grants the grantee institution is expected to assume financial responsibility or secure other support for activities supported under a grant.

We realize that in some instances these requirements present hardship to some grantees when other sources of funding are difficult to obtain. We are therefore prepared, as our grants reach the five year maximum term, to consider funding for an additional year or two if the grantee can demonstrate that such an extension is needed as a temporary expedient in anticipation of alternative sources of support.

Having demonstrated the great importance of genetic services, we believe that their funding should now be picked up by other mechanisms of payment. Since third party payers, including both medical insurance and Medicaid, frequently do not cover these services they must be paid for either by the patients themselves or by supporting grants from the federal or state governments.

We strongly endorse enactment and funding of a national genetic diseases act which will enable the state agency administering maternal and child health programs to maintain and develop genetic services. The services operated by the grantees of the Foundation should form the base of expertise for the planning and delivery of genetic services under state plans submitted in implementation of such an act. It is essential that the funding under such an act be sufficient to maintain and expand these genetic service centers as part of the state plan so that comprehensive services of high quality will become available to all.

March 7, 1978

March 13, 1978

Dear Dr. Murray:

I want to thank you for your excellent testimony before the Health Subcommittee of the Senate Human Resources Committee on March 1 concerning the National Genetic Diseases Act Amendments which I have introduced.

As I mentioned at the hearing, because time was so short I would like to submittto you some additional questions to be included in the hearing record:

1. At the hearing I asked your opinion regarding mandatory testing. Do you feel that any circumstances would warrant mandatory screening?

2. Do you feel that genetic services are reaching the economically disadvantaged, the rural populations, and minority groups? If not, how can we correct this problem?

3. What role do you feel states should play in planning for genetic services?

4. How can we assure that a good pilot program will be adopted on a wide-scale basis?

5. As the public becomes increasingly aware of genetic services, will we be prepared to meet the demand?

6. How can we assure quality of services in screening and testing? Where should liability lie in terms of testing, or when a mistake in test results occurs?

Again, thank you for your testimony and your continued interest and cooperation.

Sincerely,

Jacob K. Javits

Robert Murray, M.D.
College of Medicine
Howard University
Box 75
520 W Street, N.W.
Washington, D.C. 20059

HOWARD UNIVERSITY
COLLEGE OF MEDICINE

DEPARTMENT OF PEDIATRICS AND CHILD HEALTH
DIVISION OF MEDICAL GENETICS

March 29, 1978.

REC'D MAR 3 1 1978

The Honorable Jacob K. Javits
United States Senate
Committee on Human Resources
Room 4230
Dirksen Senate Office Building
Washington, D.C. 20510

Dear Senator Javitz:

This is in response to your letter dated March 13, 1978 in which you asked me to respond to six additional questions to be included in the record of the hearings before the Health Subcommittee of the Senate Human Resources Committee, March 1, 1978, on renewing and amending the National Genetic Diseases Act.

My responses to the questions posed in your letter are as follows:

1. I do not feel that there are any circumstances which would warrant mandatory screening for any genetic diseases. Only if one could demonstrate a clear and present danger to the population, at large would I consider the possibility of having mandatory screening for genetic diseases. I cannot think of such a danger that can be unquestionably demonstrated to exist for the proximate genetic future of the population at large. This question was examined in great depth by the Maryland Commission on Hereditary Diseases. The results of their deliberations and studies resulted in the repeal of mandatory PKU screening in that state.

2. In my opinion, genetic services are not reaching the economically disadvantaged, rural populations and especially minority groups. This opinion is not based on large scale surveys, which have been conducted but on impressions gathered from travel about the country, conversations with colleagues, health professionals and laymen. Limited surveys in some locales have shown, with respect to Sickle Cell screening, that the majority of people who seek testing are middle-class individuals with a better than average educational background.

   I think this problem can be corrected first, by educating physicians to the need for such services and secondly, by educating the public about the advantages of such services and how they can be located. This cannot be

accomplished overnight but will require careful planning and intensive effort and special funding over the next several years to reach those citizens who need the information and who need to take advantage of these services. The sickle cell programs, in their short history, I believe, have demonstrated one way that this may be done. Of course, the methods of education and outreach should be tailored to fit the peculiarities of specific genetic disorders and/or populations at risk.

3. *I feel that the states should begin to incorporate genetic services to an ever increasing degree in their public health and health care programs. As you know, each state has its own peculiarities with respect to population distribution and the availability of professional services. Each state would, therefore, have to set up regional pilot programs to determine what their needs are, what special problems exist and how these can best be served. These could be followed by demonstration projects to show that such services can be adequately delivered before being launched on a statewide basis. This means that it might take the next three to five years with federal support as well as some state financial support to carry out these preliminary programs before we might be able to say that genetic services could be safely, reliably and beneficially deliveyed to the entire population of a given state.*

4. *One way of assuring that good pilot programs would be adopted on a broad scale basis would be to tie federal funding to the development of such pilot programs during the first two to four years in which states might be able to apply for funds to establish programs to provide genetic services where none had previously existed. The structure and organization of the pilot programs would be reviewed by a committee of peers or experts who would be certain that the pilot programs were high quality and were properly designed to reveal potential problems that might arise in genetic screening and to identify problems yet unforeseen that might be detrimental to more comprehensive statewide programs.*

5. *We will not be prepared to meet the demands for genetic services unless we begin <u>now</u> to expand the training of health professionals already providing services and to expand the pool of competent professionals with special training in delivery of genetic services and in particular - genetic counseling. This might mean that we should support the <u>temporary</u> increase in the number of persons trained to do genetic counseling and make long range plans to be sure that there is an adequate supply of*

persons with special training in this field and related supportive fields, e.g. child development programs and disability counseling and training programs. If public education is properly phased with training of genetic counselors and other persons specially oriented in genetic technology we will be less likely to stimulate public demand beyond the availability of services. This means that some sort of broad-based plan is essential to the development of the kind of genetic services program that will clearly have a positive impact on American citizens.

6. Perhaps the most reliable way of assuring that quality of services in screening and testing will be adequate would be to have these services monitored by either statewide or preferably a nation-wide quality control program. The Center for Disease Control serves as such a capacity in sickle cell testing and could expand its program of quality control to include other genetic diseases. Each testing center, or laboratory should be able to demonstrate that its director and technical personnel have met some minimum standard for training and experience before that laboratory would be recognized as an official genetic testing laboratory. Since the number of people involved in such services will probably not get to be extremely large, it is probably not best at this time to begin a program of state or national licensure. Most people who have considered this problem suggest that there be accreditation of testing and counseling programs and there would be routine monitoring of them to assure that only the best quality of services would be delivered.

I am not certain where the liability should lie when errors are made in genetic testing. One could follow the general medical model in which the physician who orders the test is finally responsible for the damage that comes from errors in the test. However, the techniques used in genetic testing, such a chromosome analysis, special biochemical methods; including radioactive labeling techniques, and/or immunologic assays suggest to me that the brunt of error should be placed on the shoulders of the laboratory performing the test. It is, of course, up to the genetic counselor or physician to verify that the test is correct and that it is consistent with their clinical impression. Because the implications of genetic testing are so broad and far reaching, i.e. they extend into future generations of the family, I would suggest that perhaps all genetic tests should be repeated to verify their accuracy before being accepted as definitive. This would increase the expense of testing somewhat, but I believe that a person

should be considered innocent of carrying a genetic trait until proven guilty. This is one of the issues in genetic testing which, I feel, deserves intense scrutiny and study. The National Commission for the Protection of Human Subjects or any other such deliberative body concerned with the ethical issues involved in testing, as well as the legal issues, should investigate this and other questions very intensely. It is one of those items which was not studied or at least not studied in depth by the group that promogated guidelines for development of programs for genetic screening and testing.

Thank you very much for the opportunity to respond to these questions. I would welcome the opportunity to assist in any way I can to promote the passage of this vital legislation. I feel that it is vital that we develop these services and that the support of such a bill with its full appropriation would help assure that American citizens would have the best program of genetic testing and service in the world. You are to be commended for your wisdom in promoting this program.

With best regards,

Robert F. Murray, Jr.

Robert F. Murray, Jr., M.D.
Professor, Pediatrics & Medicine
Chief, Division of Medical Genetics

RFM/med

March 13, 1978

Dear Mrs. Marks:

I want to thank you for your excellent testimony before the Health Subcommittee of the Senate Human Resources Committee on March 1 concerning the National Genetic Diseases Act Amendments which I have introduced.

As I mentioned at the hearing, because time was so short I would like to submit to you some additional questions to be included in the hearing record:

1. In your testimony you stress the problem of lack of knowledge within the medical community. Are the instances frequent when lack of knowledge interferes with good care?

2. Do you think that federal funding for education programs will be effective in tackling the problem of lack of knowledge?

3. We are witnessing teenage pregnancy in epidemic proportions. Given the problem of providing even basic sex education and contraception information, how would you assure provision of genetic counseling to these teenagers?

4. How well informed do you feel the general public is in terms of genetic services and their availability?

Again, thank you for your testimony and your continued interest and cooperation.

Sincerely,

Jacob K. Javits

Mrs. Joan H. Marks
Director
Human Genetics Program
Sarah Lawrence College
Bronxville, New York 10708

SARAH LAWRENCE COLLEGE
BRONXVILLE, NEW YORK 10708

TELEPHONE
914 337-0700

March 20,1978

Senator Jacob Javits
Senate Office Building
Washington, D.C. 20510

MAR 27 1978 LCD

Dear Senator Javits:

Thank you for the opportunity to respond to some questions which time did not allow at the Health Subcommittee of the Senate Human Resources Committee hearing on March 1. My answers are:

1. Absolutely. Families who eventually reach genetic centers have tragic histories of spending years and countless sums of money trying to get a diagnosis for their genetic problem. Often they have parented more than one child with the same condition without any understanding that the condition was heritable. Every genetics unit in the country can document misdiagnoses, based more on lack of knowledge than on incompetence.

2. I believe federal funding will give the impetus to a vital educational program. Once such a program is established, and its positive effects realized, funding will be forthcoming as it almost always is when innovative programs prove their worth. Then genetics would be incorporated in on-going programs of public and professional education.

3. The question of providing genetic counseling to teenagers within programs of teenage sex education is a challenging one which has not, to my knowledge, been attempted. However, pilot studies to identify those teenagers with a family history of genetic disease could be developed. Once identified, these teenagers could be informed as to their future need for comprehensive genetic counseling as well as given some basic information about inheritance appropriate to their age and level of interest.

4. I strongly believe the general public is almost totally uninformed as to the role genetics plays in human disease, does not begin to understand how heredity affects their reproductive lives, and certainly is unaware of the availability

genetic services. Despite three million births a year in the United States and a well-documented risk of bearing a Down syndrome child at age 35 and older, no single institution - public or private - has effectively transmitted this message to the public. Not only is this an important message to get to the public because of the availability of prenatal diagnosis to determine the presence of an affected child, but the statistics show the age at parenthood to be increasing rather than decreasing!

The genetics community is indebted to you for your continued support and determination to institute a federal program to bring genetic services to our citizens.

Sincerely yours,

Joan Marks

Joan H. Marks
Director
Human Genetics Program

JHM:mlz

March 13, 1978

Dear Mrs. Guthrie:

I want to thank you for your excellent and heartfelt testimony before the Health Subcommittee of the Senate Human Resources Committee on March 1 concerning the National Genetic Diseases Act Amendments which I have introduced.

As I mentioned at the hearing, because time was so short I would like to submit to you some additional questions to be included in the hearing record:

1. What discrimination do patients and families with genetic disease suffer in terms of job security, life insurance, and other problems?

2. Are there other services we could be providing in addition to those we have included in the legislation?

3. Should we be doing more in terms of long-term counseling for the chronically ill, particularly for those suffering from diseases for wwhich there is no treatment? Is there sufficient psychological and psychiatric counseling?

Again, thank you for your testimony and your continued interest and cooperation.

With best wishes,

Sincerely,

Jacob K. Javits

Mrs. Marjorie Guthrie
Committee to Combat Huntington's Disease
250 W. 57th Street
New York, New York

A Voluntary National Health Agency founded in 1967

COMMITTEE TO COMBAT HUNTINGTON'S DISEASE INC.

CCHD DEDICATED TO DETECTION AND CARE OF THOSE WHO SUFFER HUNTINGTON'S DISEASE AND TO ITS ERADICATION THROUGH RESEARCH

250 West 57th Street New York, New York 10019 (212) 757-0443

March 20, 1978

REC'D MAR 2 1 1978

The Honorable Jacob K Javits
321 RSOB
Washington, D C

Dear Senator Javits:

Thank you again for the opportunity to respond to the three specific questions which you asked concerning the need for the NATIONAL GENETIC DISEASES ACT.

For ten years since the formation of the Committee to Combat Huntington's Disease, we have been collecting data from the many families who come to us for help, for information and, most important, for assistance relating to the problems concerning their jobs, life insurance, coping with financial needs, discrimination within the Veterans Administration, etc., to name only a few. Let me cite examples:

1) A young man (D. C.) had three more years before he was entitled to full retirement benefits from the Navy. Because he was "at risk" for H D, an effort was made to retire him prior to the appropriate time, and this would have reduced his benefits drastically. We arranged for a neurologist to examine him. The doctor reported that, at this time, the "potential" patient was NOT an H D patient. With a great deal of effort on our part, and with the help of our professional friends, we established his right to remain in the Navy, and when his full tour of duty is completed he will receive the benefits due him.

The effort to fight this kind of battle has increased his fears and, who knows, perhaps has brought the onset of H D just that much sooner, if indeed he ever really becomes a patient. This kind of stress is going on in many families. The threat of losing a job, of being held back rather than promoted, of being cut off from insurance IF the knowledge of H D surfaces, is well documented. Young people who know of the possibility of H D in their futures, because of these anxieties and fears, have, in some cases, taken on the manifestations of H D. To our surprise, after a period of time, the symptoms disappear. The individual is still "at risk," however, and may become a patient at some future time.

Another example: a young man (A. W.) was diagnosed as having H D by a competent, knowledgeable neurologist, and TEN years later, with the symptoms seemingly remaining the same, has now been told that he does NOT have H D. This man, now forty years old, is hoping to pursue his education in college, planning to make up the ten lost years.

2) There have been suggestions that this legislation should include some plans for screening, as a form of early detection, where, through amniocentecis, some genetic disorders might be diagnosed. I felt that this was inherent in the meaning of the word "detection." This might be clarified.

3) Long term counselling, in my opinion, means that all along the way, from the time that a family learns of the particular inherited disorder, every member of the family should have the opportunity to discuss HOW they are going to COPE with this information. What is helpful to a parent or to a child differs from year to year, depending on many factors: whether or not a parent with the disorder lives in the home; the number of patients in a home; the age of the child who is a witness to the onset and deterioration of his parent, etc. Differing circumstances bring different responses from each member of a family, the community, the physicians, etc. As the family becomes aware of a disorder like H D there is a great need for someone to turn to and it is important to note that where the family does have financial resources for better care, in the home, with psychological counselling, etc., the patients do NOT DETERIORATE AS RAPIDLY OR AS SEVERELY as those who don't have such support.

Our experience points out that if and when supportive services are available patients do not need years of hospitalization, and are capable of maintaining themselves in their homes for longer periods of time, even though there may be ongoing brain cell loss and physical deterioration. Patients may become mentally and physically handicapped, nevertheless they are capable of developing methods for coping within their limitations. While there is no recognized treatment for H D we believe that just CARING is a form of treatment and should be available to all. Handicapped people can and must have the right to make their contribution to society. Being a part of the world is another vital form of treatment.

There is undoubtedly going to be an explosion of information about inherited disorders in the next few years. We must make every effort to assure patients and families with inherited disorders that as knowledge becomes available they will have the information for testing, treatment, whatever... as soon as possible, on a voluntary basis. But the people must know WHERE to go, and to WHOM they can speak. The HOPE from just looking ahead is another vital form of treatment.

I do hope that these comments will be helpful in consideration of this act. Our Huntington's Disease Commission has documentation from all over the country which is available to those who wish for more in-depth information.

I look forward to further discussion of this bill with you.

LOVE & PEACE!

Marjorie Guthrie
Founder/ Pres. Emeritus

MG / ic

Senator JAVITS. Thank you all very much.

Senator KENNEDY. Could I add my warm word of welcome to all of you. I have had a chance to be aware of the positions that all of you were speaking to, and I just want to let you know that you have all my help and support in terms of legislation as well. Thank you.

Senator JAVITS. Thank you for the very generous statement you made in opening this hearing. I deeply appreciate it. It will encourage me and the supporters of this legislation to carry it on to consummation.

Thank you very much for your indulgence.

Senator KENNEDY. We will now have our final witness, Mike Gorman, an old friend.

STATEMENT OF MIKE GORMAN, EXECUTIVE DIRECTOR, CITIZENS FOR THE TREATMENT OF HIGH BLOOD PRESSURE, INC.

Mr. GORMAN. My statement will be brief. If I may submit the full statement——

Senator KENNEDY. We will include it in the record.

Mr. GORMAN. Just a couple of comments, Senator, directed to the difference between this bill, the House bill, and the administration bill. I think that the key issue involved here is block grants—well, one thing I will say, since we went to Secretary Richardson in 1972, Dr. DeBakey, Mrs. Lasker and your humble servant, the death rates in the United States have been reduced over the past 3 years, over the past 5 years. We have had 300,000 less deaths. A major reason for this is the hypertension program. This is the National Center for Health Statistics data I refer to in the text.

Now we have a very small formula grant, and it is at $11 million. It goes to 50 States. All 50 States participate in this.

I sent a questionnaire to them. This is attached to my statement. Thirty-six of the States agreed that they wanted separate categorical hypertension grants continued, even if block grants were developed eventually, whether title III of the Rogers bill was passed, which requires further incentives and so forth, that they still wanted the hypertension grant preserved as a separate entity.

Now, the position of our committee, very simply, Mr. Chairman, summarizing a lot of discussions we have had, is that we are very glad that you are renewing it for 1 year at least, and I quote you, "so that we may consider this entire problem in relation to a comprehensive review of public health and disease control programs."

In other words, that later in the year you are promising us a review of all prevention and detention programs with the hope hypertension will come out with a lot more than the $11 million we have now; we feel like paupers at the present time.

One final comment. I think this is germane to the legislation before you, and incidentally I might say this parenthetically about the administration position. The administration also agrees with us; they have not yet set up their block grant proposal, as you probably know. They have agreed that hypertension should be excluded from it. It should be a separate grant program.

Dr. Richmond testified before this committee on February 9, and before Mr. Rogers last week, to that effect.

We are happy we can agree with the administration and we can even agree with the Office of Management and Budget, which is a very difficult thing to do some of the time.

One final comment about the Rogers bill, which has a lot of good features in it and will be the subject of conferences between your two bodies. It is H.R. 10553.

Now, in that bill we are lumped in with rat control, lead base paint poisoning, and so on. We do not think that is very good billing. We do not think that is good billing at all for a program basic to the health of so many people and which has demonstrated the first successful preventive program against a chronic disease. It really works. There has been no program before.

As I say, we do not know how it is going to come out. We have testified before Mr. Rogers. We did last week. We said then that of course he could include all he wants in the block grant, but the hypertension formula program is an entirely separate program, and it is now in its fourth year historically. It has the support of the State health officers. It should be at a level of $30 million or $35 million a year. We can prevent deaths; we can prevent morbidity. It is not a small problem. I do not denigrate the wiping out of rats. I do not denigrate taking lead off walls of buildings. But I think our program deserves to get major billing. We have to come out of the minor leagues somehow, and that, in essence, is the thrust of my plea, sir.

Senator KENNEDY. Thank you very much. We might have some other kinds of questions. Let me just ask you in a broader context, we are concerned about the general kind of issue of preventive health, and I think that point has been emphasized by a variety of different members of this committee and the importance of it, under what conditions would you see the stress on hypertension a part of a preventive health care program?

What would be the criteria which would have to be met before you could support it?

Mr. GORMAN. You are asking the fundamental question, what is going to be in the bill? What is going to be in this prevention and detention effort that will be the components of a major bill?

I would say that two of the lead items in the bill would be anti-smoking and hypertension. I would think they would be two obvious emphases. If you can prevent people from smoking, you can stop 80 percent of lung cancers, which is now the second leading cause of cancer resulting in 94,000 needless deaths a year. Not academic.

And in the field of hypertension, where, if we could get at 10 million people who have uncontrolled hypertension, 10 million people who do not know they have it, it has not been detected, we could save many lives.

Now, what else is included, I sometimes worry about that. I noticed a reference this morning in the Blue Sheet and it did refer, whether correctly or not, Senator, I guess this can be on the record, I do not see why not, it said the new Kennedy prevention bill still being drafted will cover comprehensive public health services, hyper-

28-386 O - 78 - 24

tension, disease control, venereal disease, genetic diseases, and lead-based paint programs.

I think if you get too big, you get ineffective. I am in no position to lecture this committee. But I came to this city to work for Mr. Truman, and I have had some experience. I think when you get a broad spectrum bill in which you include everything, that it is not going to do the job. You have to pick two or three programs and show that prevention can work, that you can really prevent disease.

If I can make one final statement. I am a supporter individually, as is Dr. DeBakey, of the Health Security Act. We know that the major inhibition to its passage is that each year that we do not pass it, the costs keep going up 15 percent a year, almost inevitably. Unless you can keep peaple out of hospitals and, in many cases, out of doctors' offices, what we are treating is the end result of neglect. We have got to educate our people to take care of themselves. The person who smokes, boozes it up with a quart and a half a day, and also is 25 pounds overweight, all these things, and then he goes to a doctor and says fix me up, make me like new. I want to look like Robert Redford. The doctor treats him, but does not make him look like Robert Redford.

That is medical care in the United States today.

[The prepared statement of Mr. Gorman and additional material supplied for the record follows:]

TESTIMONY ON HEALTH SERVICES EXTENSION ACT OF 1978 (S. 2474)

BEFORE SENATE SUBCOMMITTEE ON HEALTH & SCIENTIFIC RESEARCH

by

MIKE GORMAN, Executive Director, Citizens for the

Treatment of High Blood Pressure (DR. MICHAEL E. DeBAKEY, Chairman)

9:30 A.M. Wednesday, March 1, 1978

Room 4232 Dirksen Senate Office Building

Mr. Chairman and Members of the Committee:

We appreciate this opportunity to submit our views on S. 2474.

We are naturally disappointed at the sum of money authorized in the legislation for only one year -- $15 million. However, we do appreciate the fact that this authorization figure at least offers us the possibility of some increase over the atrociously inadequate sum of $11 million recommended by the Administration for hypertension formula grants in both Fiscal 1979 and Fiscal 1980. This appropriation recommendation is the same as the sum voted by the Congress in Fiscal 1978. The Carter Administration does not seem to recognize the problem of inflation in the health sector, although it is very aware of it in its recommendations for the Department of Defense. An appropriation of $11 million for Fiscal 1979 would actually result in a cut of approximately ten percent in program activities because of the impact of inflation, and Lord knows how inflation would further impact the same penny ante appropriation of $11 million for Fiscal 1980. We would like to remind the Subcommittee that the $15 million authorized for Fiscal 1979 is the same amount which was authorized in Fiscal 1976.

While we are not exactly happy with the Administration figures for the

hypertension formula grant program, we are in rather full agreement with the proposal of Doctor Julius Richmond, Assistant Secretary for Health, before the Senate Subcommittee on Health and Scientific Research on February 9. Noting that all 50 States now have operative programs in the field of hypertension, Doctor Richmond told the Committee:

"We will propose the extension of this program for three years to strengthen the efforts of the States in follow-up for treatment."

We regard this statement as particularly significant because, although the hypertension program has done an outstanding job in the detection and referral for treatment of millions of hypertensives whose disease was previously unknown to them, as high as 40 and 50 percent of these diagnosed hypertensives drop out of treatment after a few months. There is an enormous need for education of the health professions and the lay public along the very simple lines that for most hypertensives medication must be taken for the rest of their lives if they are to prevent being at high risk for heart attacks, strokes and kidney diseases. Just as a diabetic takes insulin over a lifetime span, the hypertensive must take medication. However, it is not easy to change public attitudes; the difficulty in getting millions of Americans to give up smoking despite a 14-year educational campaign is a case in point.

At that same hearing on February 9, Doctor Richmond testified that the Administration would soon be submitting legislation proposing a consolidation of existing disease prevention and control programs into a single annual grant to the States. This grant will include existing authorities for disease control, lead-based paint poisoning, venereal disease, rat control and the 314(d) programs, but it will not include hypertension.

Mr. Chairman, I submit that this position on the hypertension formula grant is not an accident. The Administration has examined the needs and the effectiveness of the hypertension control program very carefully, and it has come to the conclusion that it is too large a program to squeeze into a relatively limited block grant. In adopting this position, the Administration had to convince the Office of Management and Budget, which was originally opposed to the exclusion of hypertension from the block grant.

I submit, Mr. Chairman, that it is an achievement of extraordinary magnitude to induce the Office of Management and Budget to change its mind on anything.

Mr. Chairman, we do appreciate your statement in the Congressional Record of February 1, that you are proposing just a one-year extension "so that we may consider this entire problem in relation to a comprehensive review of public health and disease control programs ... and that after our hearings and further analysis, we will have a clearer picture of these relationships and will be able to extend this legislation for three more years, or amend it consistent with other programs."

We are also delighted with your statement that "Disease prevention is one of my paramount concerns in the health field, and later in the year I intend to introduce comprehensive proposals aimed at expanding the Federal Government's commitment to preventing illness. In order to have the flexibility to integrate federal authorities in the important area of prevention, we are reserving the option of reviewing these expiring authorities later this year in the context of a broad prevention effort. We are not at this time prejudging which of these programs would, in fact, be integrated or which remain separate."

Citizens for the Treatment of High Blood Pressure welcomes with the greatest enthusiasm the opportunity to testify later in the year on a comprehensive bill in the important area of prevention of disease through a national prevention effort. As we have noted before, we think we have the best case to offer for investing a relatively few dollars in prevention and, by so doing, prevent billions of dollars in costs resulting from heart disease, stroke, kidney failure and diabetes.

The only true cost restraint to the inevitable spiraling of medical care costs in this country is a program of prevention. As Doctor John Knowles, President of the Rockefeller Foundation, stated in a December, 1977 issue of Science:

"The individual must realize that perpetuating the present system of high-cost, after-the-fact medicine will only result in higher costs and greater frustration."

This is the aim of the Citizens for the Treatment of High Blood Pressure. We want to alert millions of our citizens to the fact that they have high blood pressure and show them that it can be easily and reasonably controlled. If we fail, we had better be prepared to build another 100,000 hospital beds in this country.

Mr. Chairman, we have had a chance to examine H.R.10553, the Health Services Amendments Act of 1978. Beyond some surprise that this bill authorizes only $12,700,000 for hypertension formula grants in Fiscal 1979 -- when the same committee authorized $15 million for hypertension formula grants in both Fiscal 1976 and Fiscal 1977 -- we find Title II of the bill singularly premature. In a section entitled "Preventive Health Services," it opts for a block grant approach to a whole series of supposedly preventive programs for the years Fiscal 1980 through

Fiscal 1982. In defining what it means by "prevention," H.R.10553 merely repeats a laundry list of existing programs in the disease control area. It seems to us that it does this without any real sense of the priorities in preventive programs and without any documentation resulting from hearings on the value of each program listed.

We are not comfortable in being squeezed into this laundry list on a co-equal basis with rat control, lead-based paint poisoning, and so on. We don't deny the importance of these programs, but we feel that they have a rather low priority compared to a hypertension program which has been responsible for the most sustained reduction-in-death rates in American history. While we cannot speak for the State health officers in this area, we can certainly point to our recent survey indicating that they place a number one value upon an independent, highly visible hypertension formula grant program. All 50 States now have on-going hypertension programs; many of them are involved in massive hypertension screening and follow-up programs in close cooperation with 130 national and State medical, voluntary and fraternal organizations. In other words, this program has created a powerful identity of its own and has generated enormous public support.

The National Hypertension Program is considered today by medical authorities and by the National Center for Health Statistics as the most successful preventive effort in the history of American medicine. At a press conference in September, 1977, Doctor Michael E. DeBakey, President of Baylor College of Medicine and one of the world's most distinguished cardiologists, pointed out that

high blood pressure is a major factor in 68 percent of all first heart attacks, 75 percent of all first strokes, and 30 to 40 percent of all cases of total kidney failure.

The national hypertension effort is cutting deeply into these depressing figures. At that same press conference, Doctor DeBakey pointed out that in 1976, for the second year in a row, the nation achieved its lowest over-all death rate from all causes. He stated that his conviction was based upon figures released by the National Center for Health Statistics, that the declines in heart attacks and strokes were primarily the result of public education campaigns alerting both laymen and physicians to the danger of high blood pressure.

"The saving of these lives is one of the great feats in the history of preventive medicine in this country in the last 30 years," Doctor DeBakey stated. He mentioned that this unprecedented saving of lives that would have been lost to heart disease and strokes was a feat unimagined since the introduction of penicillin in the 1940's.

Since the inception of the high blood pressure prevention and control effort in 1972, 290,000 persons are alive today because they learned to control their high blood pressure, according to both Doctor DeBakey and the National Center for Health Statistics.

On July 21, 1977, Doctor Robert Levy, Director of the National Heart, Lung and Blood Institute, testified before a House Select Subcommittee on Aging examining the problem of why 40 percent of Americans over the age of 65 suffer from high blood pressure, with only a small percentage of these receiving treatment. Moving on to the larger picture of the extent of high blood pressure in the United States -- 24 million have already been diagnosed as hypertensive and this

is a conservative figure -- Doctor Levy revealed some sobering facts on the impact of high blood pressure upon the nation's health and upon its economy. Describing these efforts, Doctor Levy told the Subcommittee:

"The Program has been highly successful. We have seen a major change in the detection, evaluation and treatment of patients with high blood pressure. Over 6 million previously undiagnosed patients have been detected. The number of patient visits to physicians for high blood pressure has increased over 50% during the past five years. The number of hypertensives whose blood pressure is now normal on treatment has increased by almost 100% to almost 8 million and both the general public and the health care professionals are much more aware of the perils of high blood pressure and the promises offered by treatment. Of greatest importance, this new awareness of and behavior toward high blood pressure appears to be paying big dividends. Since 1972, heart attacks in this country are down over 10% and deaths from stroke have declined by about 20% in the same time period. These unprecedented gains have resulted in the reduction in the number of cardiovascular deaths in this country to below one million in both 1975 and 1976 after over a decade of more than a million deaths each year. It should also be noted that this decline has occurred despite an increasing and aging population. With these gains the average life expectancy of Americans has increased by two years in the past five years and we now have the lowest death rate in our nation's history.

"However, despite these most favorable health statistics, it is obvious that we still have a long way to go. Of the approximately 23 million Americans

with hypertension, almost 10 million are aware of their high blood pressure but are either not on treatment or they are on inadequate therapy and there are still some seven million who are unaware of their condition."

What does the Congress think of the high blood pressure program? The following excerpt from the Senate Appropriations Committee Report on Labor-HEW for Fiscal 1978 can serve as an illustration:

"Considerable progress has been made in the understanding of heart disease over the past two decades, and this research is now paying off in several ways. From 1970 to 1976 deaths due to coronary artery disease have declined by more than 15 percent, more than twice the decline from non-cardiovascular disease. In this same period, deaths due to stroke declined 22 percent and those due to hypertension by 39 percent. In 1975 the number of deaths from major cardiovascular diseases dropped below one million for the first time since 1967 despite an ever-increasing and aging population. A most gratifying trend is that the reduction in the death rate in the past several years has steepened. Yet expenditures on research aimed at reducing mortality and the cost of these diseases is less than one percent of their current annual cost.

"The sharpness of the decline coincides with the development of the national high blood pressure education program. Since 1972 this federally-coordinated effort - initiated by this Committee - involving over 200 cooperating public and private organizations, has aimed at improving physician and public awareness of the increased risk of heart attack, stroke, kidney failure, heart failure, and other killing and expensive diseases associated with high blood pressure. In 1971 less than 4 million of the 27,000,000 Americans with high

blood pressure were under adequate control. This figure has now more than doubled; there has been an increase of more than 50 percent in the number of patient visits to physicians for hypertension and hypertensive heart disease. A current objective is long term maintenance therapy. A portion of the increased funds provided in this bill should be used for this important and effective program."

How do the States feel about the hypertension formula grant program? On November 30, 1977, Citizens for the Treatment of High Blood Pressure, in cooperation with the Association of State and Territorial Health Officials, sent a detailed questionnaire to all 50 States soliciting their frank opinions on the hypertension formula grant and its effectiveness. Summarizing the results of the State health officers as briefly as possible, 36 of the 42 States which returned the questionnaire stated emphatically that the Fiscal 1978 funding level of $11 million for these grants fell far short of even the minimum needs for an effective screening, detection and follow-up program.

Of the 36 States responding in the positive, the vast majority of them expressed a willingness to advocate at least $30 to $35 million a year over the next three years for these hypertension formula grants -- an approximate tripling of the present level of funding.

We have appended to this statement a summary of the replies from the State health officers and a selection of excerpts from their replies which indicate the problems they are facing due to inadequate funding.

In House testimony in 1977, Doctor Joseph Wilber, Director of Adult Health Services of the State of Georgia and President of the Georgia Heart Associa-

tion, gave his verdict on the hypertension formula grant program on behalf of his fellow State health officials. Here is what Doctor Wilber told a House committee:

"It was the impetus of the passage by the Congress of the 1975 Health Services Act which gave the necessary push to the States. Today, all 50 States have begun high blood pressure programs, and for the first time we are seeing an increasing national recognition that this is a common public health problem where results can be seen in terms of reduced disability, deaths and health costs immediately if the majority of the people with high blood pressure can be detected, educated and treated. It would be a tremendous step backward not to increase the funds available to the States at this time when their programs are just getting under way.

"We hear a lot these days about keeping health costs down, and properly so," Doctor Wilber continued. "The greatest cost constraint you can initiate is prevention of disease. The high blood pressure program I am talking about on behalf of my fellow State health officials is the first preventive program being launched against a major chronic disease. It keeps people out of hospitals, because 99 percent of its victims can be treated on an ambulatory basis. For example, chronic kidney failure requiring kidney dialysis costs $20,000 a year for each patient hospitalized. In our experience in Georgia, we have found that anywhere from 25-50 percent of those suffering end-stage kidney failure could have been treated successfully if their high blood pressure had been detected and treated earlier. I could use the same arguments in the case of stroke. High blood pressure is the major cause of strokes, and we all know that the total cost of hospitalizing a stroke victim is staggering."

In very simple terms, Mr. Chairman, we have two primary objectives at the present time:

(1) A one-year renewal of the hypertension formula grant program at a level of at least $30 million -- the minimum amount suggested in the November, 1977 survey of the State health officers.

(2) An opportunity to demonstrate at hearings later this year that we are the best possible example of a preventive program against the leading killers of our day, and that we should be viewed as such in the drafting of any realistic disease prevention program. If we can help it, we do not intend to lose our visibility by becoming submerged in an amorphous block grant program which merely throws a bunch of existing programs into one lump called "prevention."

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CITIZENS FOR THE TREATMENT OF HIGH BLOOD PRESSURE, INC.

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MEMORANDUM

SUBJECT: REPLIES TO QUESTIONNAIRE ON STATE HYPERTENSION PROGRAMS

FROM: Mike Gorman, Executive Director, Citizens for the Treatment of High Blood Pressure

On November 30, 1977, through the good offices of Doctor Lyman Olsen, President of the Association of State and Territorial Health Officials and with the cooperation of its Washington office, we sent out a detailed questionnaire soliciting opinions on the current State hypertension formula grant.

We were most encouraged by both the quantity and the quality of the replies. Forty-two States responded, most of them at considerable length. These are just a few of the highlights of the survey:

(1) ATTITUDE TOWARD PRESENT HYPERTENSION FORMULA GRANT

The vast majority of the State health officers expressed their strong support for retention of the present formula grant as an independent and visible program. They were almost uniformally opposed to any attempt to lump the present grant into an over-all primary project grant. They argued, quite persuasively, that hypertension monies should not be distributed to grantees at the community level. The disease of hypertension is endemic in all 50 States, and it should be handled by State health departments.

(2) ADEQUACY OF EXISTING FORMULA GRANTS

This question elicited the sharpest response. Thirty-six of the 42 States stated very emphatically that the Fiscal 1978 funding level of $11 million for these grants fell far short of meeting even the minimum needs for an effective screening, detection and follow-up program. Five States were against any increase in funding, while one other State took no clearcut position.

Of the 34 States responding in the positive, most of them expressed a clear willingness to advocate at least $30 - 35 million a year over the next three years -- an approximate tripling of the present level.

The State health officials spelled out in considerable and fascinating detail descriptions of their existing hypertension programs followed by an outline of how many more people could be reached with additional funding.

In the attachment to this summary, we include excerpts from some of the State reports so as to give everyone interested in hypertension control some indication of the wide variety of techniques being used at the present time, both to detect hypertensives and to keep them on treatment.

(3) COVERAGE OF AMBULATORY CARE FOR HYPERTENSIVES

Because there was disagreement last year between the two bodies of the Congress -- with the House voting for coverage of ambulatory care "where appropriate" and the Senate holding to "referral for treatment," we included a question designed to obtain the attitude of the State health officers on this issue.

Despite the controversial nature of this issue, the response of the State health officers was overwhelmingly on the side of the House position. Thirty States voted for ambulatory coverage; six States voted against it, and in the case of the other six States it was difficult to discern a clear-cut position on the issue. As to what percentage of the formula grant should be allocated to ambulatory care, the figure of ten percent was most frequently used; however, some wanted somewhat less than this, while a number wanted anywhere from 15 to 30 percent used to defray medical and drug expenses for indigent patients. Of course, practically all of these responses were predicated upon a considerable enlargement of the present formula grant.

In some of the communications, there were suggestions that more experience had to be gained by this relatively new program before one could talk factually on the pros and cons of the issue. In fact, several States this year are conducting just such an inquiry to find out how many of the screened patients cannot pay for medical care and medications.

It is our feeling that when hearings are held this year on the renewal of the legislation, this issue may be resolved. However, since there is a likelihood that there will be just a one-year renewal of 314(d) programs, the better strategy might be to concentrate on obtaining a more adequate sum under existing law and postponing until next year the resolution of this matter.

If any of you would like a full set of the replies, we can accommodate you. In return, would you be good enough to let us have your very frank reaction to the results of this survey?

ATTACHMENT

EXCERPTS FROM QUESTIONNAIRE ON HYPERTENSION FORMULA GRANTS

ALABAMA

As a nation we are now on our way to spending two billion dollars a year to treat end-stage renal disease. Good sense dictates that we can well afford to spend more than 11 million to help prevent it. Here in Alabama, Dr. Thomas Andreoli, director of nephrology at the University of Alabama, indicates that 30 percent of the 200 to 300 new kidney failure cases in Alabama each year result from uncontrolled hypertension.

Mortality and morbidity from uncontrolled hypertension is the most endemic problem we face today. Funds to deal with this problem can no longer continue to be so disproportionate to the need. The formula grant program is working in Alabama and we need more of it.

ARIZONA

In summary, we strongly support increased funding to at least the suggested level of $30-35 million per year over the next three years...Only recently has hypertension begun to be addressed with any regularity. To reduce or withdraw funding at this point would seriously jeopardize the progress being made in controlling a major chronic disease problem as evidenced by the reduction in hypertensive disease-related deaths in recent years.

FLORIDA

Florida's allotment is inadequate to meet the needs of the Hypertensives in Florida. Additional funding is needed to provide a comprehensive statewide education, detection, and treatment program throughout the state. Special emphasis is needed on the diagnosis and treatment aspects of our programs which we consider a priority. Funding should be increased by a minimum of 100%.

GEORGIA

Our grant of $270,000 has been invaluable in supplementing the $550,000 in state funds for ongoing hypertension control programs in Georgia. In eleven health districts in our state, these funds plus state funds have allowed us to train public health nurses, dietitians and health workers in hypertension control. This has resulted in over 100,000 adults being screened, 16,000 hypertensives identified and referred for diagnosis, and 6,000 entered in a public health program for long term maintenance assisting private physicians in lifetime blood pressure control.

ATTACHMENT - (2)

ILLINOIS

Our department is emphasizing the evaluation of effectiveness and cost of each of the 17 programs in hypertension control funded by our department and carried out by local agencies. We believe that support of a variety of approaches, each with careful evaluation of effectiveness and of cost, is our first responsibility. We define effectiveness as the numbers of new cases of hypertension remaining under documented control 6 months after onset of treatment.

IOWA

We are in the process of surveying some 6,500 persons who participated in screening programs in 1975 to evaluate the effectiveness of the screening and referral. One question asked relates to the reasons the patient stopped taking medication. Results of this survey should be available in approximately three months.

KENTUCKY

Although the hypertension formula grant to Kentucky exceeds $100,000 per year, that amount is inadequate to serve the total need of hypertensives in the State. We are definitely in favor of increasing the appropriations of States for their hypertension programs but favor the present formula based upon per capita income within a State and the estimated hypertensive population.

MARYLAND

Presently our 314D funds are being utilized to coordinate and improve existing resources. We have a High Blood Pressure Commission which is broadly representative of provider groups that reviews and advises on expenditures of these funds. Based on current requests from local communities and our State's 5-year plan, approximately $550,000 a year is needed on a permanent basis to support a statewide program for controlling high blood pressure. With this amount of funding, which is minimal - about $1 per hypertensive in Maryland - assistance can be provided to existing health care resources to enable them to bring most hypertensives under control. Our present allotment is not adequate and we are not able to meet the needs of local communities.

Therefore, we would be strongly in favor of tripling the amount of 314D funds currently available for high blood pressure.

MICHIGAN

There is no question that the present amount of resources available to Michigan from the current formula grant is insufficient to cover the existing needs in the

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ATTACHMENT - (3)

state. Our current allotment supports eight limited demonstration projects serving only a small fraction of the population in need. To mount a statewide program, we estimate would require about three to four times the amount currently available. We would therefore strongly support a proposal to increase the overall national allotment and the minimum of $100,000 per state per year.

MISSISSIPPI

Mississippi's hypertension problem extends to approximately 20% of the total population over 18 years of age. This percent represents about 280,000 people with a diastolic pressure of 90 or greater.

The Mississippi State Board of Health's hypertension program is predicated on ambulatory care. The number of participants in the program as of November 1977 is 10,622. Upon entering the program, hypertensives receive the following services: EKG, clinical chemistry, coulter series, blood sugar, chemical urinalysis and chest x-ray. All patients in the program regularly obtain medications and blood pressure checks through the county health departments.

The Board of Health's allotment for hypertension is inadequate to meet the needs of hypertensives in the state. As mentioned above, all drug monies are now exhausted. The agency advocates at least $30 million a year over the next three years for hypertension programs. A floor dollar amount is a good idea provided that it is established at an equitable level.

MONTANA

We believe that the most useful measure of the effectiveness of a hypertension control program is the proportion of diagnosed hypertensives referred who remain on drugs and under medical management over a given period of time, e.g. 1 or 2 years after referral or longer. Screening is only the beginning of prevention: long-term medical management (including drugs) is the true prevention.

NEW JERSEY

The need for a statewide coordinated hypertension control effort is evident, based upon the previous years' experience...A statewide survey to document resources, gaps and duplications of service will be completed in February of 1978. Demonstration service projects have been funded over the past 15 months to develop workable, practical models for community-based programs.

NEW YORK

The fiscal 1978 allotment is deeply appreciated by New York. There is no question, however, that it is hopelessly inadequate to the task. We would heartily endorse an increase to $30 - $35 million.

ATTACHMENT - (4)

NORTH CAROLINA

A citizen's survey indicates that there are 754,600 persons who have high blood pressure, and it is estimated that approximately 60% are not under adequate control. An additional 339,000 adults over the age of 18 have hypertension but are not aware of it. The present allocation does not permit us to fully address this problem. North Carolina supports the increase of the Hypertension Formula Grant to $30 million each year for the next three years. We also support the principle that no state receive less than $100,000 per year.

SOUTH CAROLINA

In South Carolina we estimate that there are 450,000 persons with blood pressures over 150/95. Our allocation of $177,000 does not approach a reasonable sum to address this problem. We are fortunate to have limited State funds for this purpose as well but still can only begin to meet the needs identified. We would strongly support allocation of $30 to $35 million for high blood pressure control.

TEXAS

Our current allotment is inadequate. We will need approximately three to four times our current allotment to establish and maintain the desired services on a statewide basis.

UTAH

States should have legislative authority to allocate funds, at their discretion, for purchase and distribution of antihypertensive medications, when individual need is clearly indicated. A precedent has been set by immunization and tuberculosis programs whereby both use federal funds to purchase "drugs" used in disease prevention and health maintenance.

VIRGINIA

The current allotment is not adequate to handle the number of hypertensives in the state. An appropriation of $30 to $35 million per year would be a realistic figure to meet current objectives, but would need to be higher to provide medication to all hypertensives in the state who could not afford to pay.

HAVE A HEART

The Story of an Attempt to Enroll Three Children in a Heart Clinic Sponsored by the Miss. State Board of Health

On March 1, 1977 the Macon Day Care social worker called the Noxubee County Health Department to sign up three children for a heart clinic. Physical examinations by volunteer physicians had shown heart irregularities that were referred for more thorough diagnosis. The social worker had learned from a Head Start worker that there was a heart clinic to be held in Macon during March and that blood work and x-rays needed to be done. On the phone, she was told to bring the children over to the health department. There the nurse told her that it really hurts little children to have so much blood drawn and that she would have to take them to the hospital for blood work and x-rays.

On March 2 she came to our Combined Community Child Development social work staff meeting in frustration. We called the Regional Health Department office for an understanding of their procedure. Noone was there but the secretary. From her, we learned the phone number of the Cardiovascular Department at the State Board of Health. The director there immediately returned our call and informed us that a heart clinic was to be held in Macon on March 20 and that forms requesting an appointment must be on her desk by March 13. To have those forms filled out by Health Department staff would require the completion of blood work and x-rays. She said it was not uncommon practice to use hospital facilities if the local health department did not have them. Next we telephoned Dr. Tom Waller, Regional Health Officer, working in a county office. He said he would investigate the reason for Noxubee County not doing blood work. It should be done there as there were no funds to pay for work done at the hospital for non-Medicaid patients. A little while later, Ms. Stafford, supervising

nurse called to say that blood tests could be done at the Noxubee Health Department on March 7 when children could be seen by a doctor (which she then said wasn't necessary if we had signed doctors' referrals). X-rays could not be done until May 15, too late to meet the Heart Clinic appointment deadline, she chuckled. When I demanded that x-rays done on the 15th be noted on March 13 forms, she granted that she could call the State Board and arrange for that permission. Although it seemed clear in our discussions that the preliminary workups could be done without parents taking off from their jobs, if the social worker obtained their permission, we decided to call the State Board again to verify that there wouldn't be any slip-ups. This time we talked with an assistant in the Cardiovascular Unit. She took the names and addresses of the children and the social worker and said she would watch for the x-rays when they arrived at the State Board for processing. Then she asked the ages of the children.... 3, 4, and 5. She asked, "Why aren't you signing them up to see a Pediatric Cardiologist?" She asked how far we were from Starkville (where we were at the moment) or West Point or Columbus. She said that the interns in the regular heart clinics didn't like to fool with children and would just refer them to the Pediatric Heart Clinics on April 3 in West Point or on May 5 in Starkville or May 6 in Columbus. We told her we didn't know such clinics existed. She said not to feel bad, most of the health department staff didn't know about them either. She would be glad to schedule appointments for our children for West Point but we would need to get the preliminary workups in West Point. Then she agreed that with a phone call from her and a follow-up call from us to both Noxubee and West Point Health Departments we should be able to arrange for a transfer of workups done in one place to the other for the scheduling request to be made to be sent to Jackson.

There are still many places where this attempt at heart screening can go wrong. The Health Department may yet demand parent participatio n on days when parents can't leave work, the children may get colds, the transfer of records may not go smoothly. But we will try. When I stopped in to see the Head Start nurse to share our information on Heart Clinics for children, she was out, but her secretary said that she knew all about them. In fact she had about quit trying to get appointments scheduled for Pediatric Heart Clinics because they are usually cancelled at the last minute.

This experience and others like it give us great pause when Members of Congress say "No doubt about it, the health departments really know how to relate to people because they've been doing it for decades."

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STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION
BEFORE THE SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH
OF THE SENATE HUMAN RESOURCES COMMITTEE
ON S.2474
THE HEALTH SERVICES EXTENSION ACT OF 1978

March 8, 1978

The American Hospital Association represents some 6,400 member hospitals, long-term care institutions, mental health facilities, and hospital schools of nursing, as well as more than 27,000 personal members. We appreciate this opportunity to present the views of the Association on S.2474, the Health Services Extension Act of 1978, which revises and extends the authority for a number of health programs contained in the Public Health Service Act. We support in general the extension of these programs and would like to express several areas of concern to the hospital field with an aim of improving and strengthening the basic statute.

Disease Control Programs

We are encouraged by the increased emphasis S.2474 places on preventive health measures. Health education, prevention, and promotion are of high priority to the AHA, and in that connection, we recently established a Center for Health Promotion to provide increased visibility and staff support to activities in support of preventive health measures. This center will also serve as a vehicle to guide AHA health promotion activities in such cases as immunization programs and programs to detect hypertension.

CABLE ADDRESS AMERHOSP

We believe that federal initiatives in the area of health promotion can best be achieved with the support of the voluntary sector. For example, last year we pledged to support HEW's Immunization Initiative--the stated goal of which was to increase the percentage of children who are fully immunized from 40 to 90 percent by October, 1979. As a result of this commitment, the AHA designed a package of materials on the need for immunization of children and distributed these materials to all member hospitals so that they could be presented to maternity patients. Increasing the child immunization authorization provided under Section 317(g)(1)(A) from $23 to $35 million for FY 1979 would add the necessary support to the private and public sector to ensure that the goal of the Immunization Initiative would be met.

Migrant Health Services

Mr. Chairman, the number of migrant and seasonal farm workers and their families in our country is estimated to be approximately 2.7 million. According to HEW's Health Services Administration, the infant mortality rate of this group is 25 percent higher than the national average. Furthermore, the mortality rate of migrant workers for tuberculosis and other infectious diseases is two and one-half times the national rate, and the rate of hospitalization is 50 percent higher than that of the nation as a whole.

Nearly half a million people received ambulatory health care services under the migrant health services program last year, but there are still many areas where, because of lack of funds, no health centers have been established. Last year funds were so scarce that services were limited to high-risk mothers and infants. Moreover, migrant families, often individuals with marginal incomes, travel from state to state in search of employment and are usually ineligible for Medicaid and other local community services. Unfortunately, the failure to obtain preventive

or primary care services often results in a need for more costly acute care in an institution.

The AHA strongly supports the extension of this program and recommends increased authorization levels. S.2474 would increase authorizations for the operation of migrant health centers to $40, $44, $48.4, $53.2, and $58.6 million, respectively, in Fiscal Years 1979 through 1983. While this additional support would permit some expansion of services provided through these Centers, the AHA recommends authorization levels of $42, $47, and $54.4 million, respectively, for Fiscal Years 1979 through 1981. The AHA endorses the amounts authorized for each fiscal year by Section 319(h)(3) which are earmarked for inpatient and outpatient hospital services for the migrant population. Also, we support the authorization of $4 million a year for project grants to assist in the planning and development of migrant health centers.

Community Health Centers

The Community Health Centers (CHC) program supports ambulatory care projects to provide services to medically underserved populations in both urban and rural areas. The services provided through CHCs address a broad range of preventive and primary health care needs, and include family-centered, multidisciplinary approaches to the delivery of health care services, including outreach and transportation. The program is now serving about 9.5 percent of the 45 million people residing in the catchment areas identified by HEW as medically underserved. Unfortunately, funding has been so limited in the past that many centers have been unable to provide the comprehensive services authorized under existing law. Because this program is an effort to address a difficult, complex problem of service delivery, and because it emphasizes preventive and primary health care services, we strongly support its continuation at the proposed new authorization levels.

We would like to endorse at this point a provision included in S.2474, in section 106, which would establish a new grant program for hospital-affiliated primary care centers. These grants would support demonstration projects to provide funds to public general hospitals or private non-profit hospitals in urban areas which primarily serve a population designated by the Secretary of HEW as having a shortage of personal health services. In recent years hospitals serving such areas have become the principal source of medical care for many disadvantaged persons. This phenomenon has placed an increasing burden on hospital emergency rooms and outpatient clinics, particularly in the provision of routine or primary health care. Further, the expansion of this demand for services has exacerbated the already serious problem of hospital deficits since many of these patients are neither sponsored by public programs nor able to pay for the services they need.

This urban initiative sponsored by Senators Jacob Javits and Edward Kennedy and others is welcomed by hospitals as a positive recognition of the unique role these urban hospitals play in serving the medical needs of the poor and near-poor in their communities. We do not believe that grants for primary care centers will completely solve the problem of assuring access to quality health care services in urban, underserved areas, nor do we believe that it will end the financial problems of urban hospitals. Nevertheless, these grants would provide much needed support to assist urban hospitals in redesigning their system for rendering ambulatory care and thus permit them to serve their patients in a more efficient and effective manner. We would be willing to work with you and your staff in further development of this innovative idea.

National Health Service Corps

Section 107 of the bill requires the Secretary of HEW to submit to Congress a special report on the present and future directions of the National Health

Service Corps. We support the Committee's call for such a report and hope that the AHA and other interested organizations will be consulted in its development.

Home Health Services

Section 110 of S.2474 would redesignate the program of federal grants for development and expansion of home health services (now section 602 of Public Law 94-63) as section 320 of the Public Health Service Act and would extend the program for three years at an authorized level of $12 million a year. In addition, $2 million a year would be authorized under this section for training home health aides and related personnel for work in these agencies.

Mr. Chairman, the American Hospital Association supports the extension of the home health grant program under section 602 of P.L.94-63 and strongly endorses the increased funding levels provided in your bill. Home health programs can be an appropriate and cost effective alternative to inpatient care, and the American Hospital Association has given the establishment of hospital-based home care programs a high priority. In this connection we want to advise you of our recently established Center for Ambulatory and Home Health Care Services. This center, located in our Chicago headquarters, will serve as a focal point for consideration of the special characteristics and needs of hospital-based home health services programs, as well as those of outpatient departments and emergency rooms.

Since its enactment in 1975, the home health services grant program authorized by section 602 of P.L.94-63 has provided needed assistance in the development of services to provide medical care to the elderly or handicapped at home rather than in an institution. Among the applicants receiving assistance under section 602 have been a number of hospital-based home health programs, and we are hopeful that the increased funding provided in your bill will enable more hospitals to receive these grants.

The AHA also supports the authorization of $2 million a year for training provided by S.2474. If home care services are to become a viable alternative to institutionalization for some patients, there must be an adequate supply of trained personnel. In addition, however, the AHA believes there is a need for more technical assistance to institutions or organizations which are interested in establishing a home care program. Those who would seek to become providers of home health services need to acquire a basic understanding of the federal laws and regulations governing home care. The Department of Health, Education, and Welfare does provide a certain amount of technical assistance through its regional offices in the form of telephone calls, on-site visits, and workshops, but this assistance must be greatly increased if home health programs are to become more widely established. To this end, we would recommend that, in addition to the funds for expansion, development, and training, funding be provided in the form of contract authority or by some other mechanism for technical assistance in both the pre-application and start-up phases of the home health grant program.

One last area we would like to address, Mr. Chairman, concerns the potential for expanding home health programs into the new area of hospice care for terminally ill patients. The term, "hospice care," refers to a comprehensive program of services, provided in both the institutional setting and at home, which has as its goal to ease the pain of the terminally ill patient, to maintain the individual's dignity and privacy, and to provide necessary counseling services to both the patient and his or her family. A well planned hospice program can help to ease the emotional pain of approaching death and, from an economic standpoint, can help to prevent or shorten expensive hospitalizations.

Hospice services that are both hospital-based and non-hospital-based are being established in a number of cities across the country. The American Hospital

Association believes that the circumstances of an individual case and the judgment of the attending physician will determine whether or to what extent hospice services should be provided in the home. In many cases, however, it will be possible to provide hospice services to the patient at home, and, to this end, we would recommend that federal assistance for the development of hospice programs (perhaps by expansion of the section 602 grant program), be provided.

Conclusion

Mr. Chairman, this concludes the Association's statement. I would like to express the Association's appreciation for this opportunity to present our views to your and members of the subcommittee and we hope it will be of assistance in your consideration of this legislation.

Senator KENNEDY. On that rather gloomy note, we will adjourn.

[Whereupon, at 12:15 p.m., the subcomittee adjourned, subject to the call of the Chair.]

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