The original documents are located in Box 17, folder "President Ford Committee - Input" of the Michael Raoul-Duval Papers at the Gerald R. Ford Presidential Library.

10/11/76

FILE

MIKE WOULD RATHER NOT RESPOND

1/

President Ford Committee

825 New Hampshire Ave., N. W., Suite 105, Washington, D. C. 20037 (202) 337 - 2727

1/14/76

Mike -
I talked to your lovely lady, Helen - & she suggested I mail this to you. This report is supposedly confidential. It seems to me the President might have this plan or something similar thrown at him out of the blue - and it's best that he be forewarned -

Sincerely -
Bill Cooper

The President Ford Committee, Howard H. Callaway, Chairman, Robert Mosbacher, National Finance Chairman, Robert C. Moot, Treasurer. A copy of our Report is filed with the Federal Election Commission and is available for purchase from the Federal Election Commission, Washington, D.C. 20463.

SCOTTISH RITE HOSPITAL FOR CRIPPLED CHILDREN, INC.
CHARTERED 1915
1001 JOHNSON FERRY ROAD, N.E.
ATLANTA, GEORGIA 30342 (404) 256-5252

August 6, 1976

Jack H. Watson, Jr., Director
Planning Office
Carter-Mondale Campaign
Suite 2500
Trust Co. Tower
Atlanta, Georgia

Dear Jack,

This position paper is not a compromise of a task force but the product of a years study by members of the Advisory Council on the Physical Health Needs of Children and Youth to the Department of Human Resources. It presents broad recommendations but each point can be justified by detailed available data.

Drafts of this document recently have been reviewed, word by word, by key national experts in this field. These consultants represent, on the national level, The National Institute of Child Health and Development of the National Institutes of Health, the Office of Maternal Child Health of the Bureau of Community Health Services, the Office of Child Health Affairs of the Office of the Assistant Secretary of the Department of Health, Education and Welfare, representatives of the American Academy of Pediatrics and American Society of Pediatrics and informal discussion with staff individuals of The National Foundation - March of Dimes.

Much of our basic data on Georgia's problem was obtained from interviews with twenty-three administrators of health programs in our state, the Council on Maternal and Infant Health as well as physicians in the private and the public sector of medicine in Georgia.

We plan to continue our study by on site visits with District Health Officers and the Chief Nurse in each health district of Georgia.

It is paramount to say, at the outset, that we have been enthusiastically received at every level and each urgently requests that something be done for mothers, infants, children and youth. We sense

a ground swell of opinion that this hope lies with Jimmy Carter and his strong leadership.

Jack, your organizational abilities to ultimately untangle the massive maze of legislative programs will get the job done. As presently operating, these programs are wasteful, inflationary, not meeting their objectives and are excluding nationally 700,000 pregnant women and one million children in need.

Our initial plan was to ask several consultants to participate with us this morning but honestly the number got our of hand. We decided to disinvite all. But each agreed to be available for a telephone conference Monday or better that each is willing to come at your request or ours for a working day or two with your staff.

Without changes on the Federal level our local problem can not be solved due to the overlapping Federal rules and regulations. We do not feel this problem is unique only to Georgia.

As advocates for mothers, infants and children we have done a poor job in the past. We are now ready to assume a more active leadership role in order that the children get their fair share. We are now convinced that this group of Concerned Pediatricians is as knowledgeable as any group in the country. Again we are encouraged that our ideas for solutions, immediate as well as long range, have been received with enthusiastic support by each agency and individual contacted. We believe these recommendations are a reasonable and affordable place to start on solving this very complicated problem.

Again, we repeat that there is an emerging ground swell that what this nation needs most is to insure the integrity of the family unit by providing non-fragmented comprehensive health care for mothers, infants, children, and youth.

Please do not misunderstand. We do not have all the answers, and do not believe that all of them will be formed soon. We stand ready to answer the call to assist further in finding solutions for problems on the Federal level while we continue to work on our local problems.

Attached is a copy of the latest draft of the paper which will be presented and discussed at the meeting on Monday, August 9th.

Sincerely,

Judson L. Hawk, Jr., M.D.
for the following Concerned Pediatricians

JLH/cm

James W. Bennett, M.D.
Alton M. Johnson, M.D
Harvey M. Newman, M.D.
Martin H. Smith, M.D.
Joseph H. Patterson, M.D.
Richard W. Blumberg, M.D.
David L. Morgan, M.D.
Richard L. Schley, Jr., M.D.
Oscar S. Spivey, M.D.
H. Luten Teate, M.D.

Recommendations to Strengthen Federal Health Programs for the Mothers, Infants, Children and Youth of America

Respectfully Submitted By

Executive Committee

Georgia Chapter-

American Academy of Pediatrics

James W. Bennett, M.D.

Richard W. Blumberg, M.D.

Alfred J. Green, M.D.

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H. Luten Teate, M.D.

August, 1976

As concerned citizens and practicing pediatricians we appreciate the opportunity of expressing our concerns regarding the health programs for the children and youth of America and to offer suggestions for strengthening them.

The Advisory Council on the Physical Health Needs of Children and Youth (The Council), was created by T. M. Jim Parham, Commissioner, Department of Human Resources (DHR), on August 15, 1975. The membership is composed of the Executive Committee of the Georgia Chapter - American Academy of Pediatrics. Its purpose is to advise DHR on matters pertaining to the establishment, operation and evaluation of the physical health programs for children, age one to twenty-one. (The Council on Maternal and Infant Health relates to the mother and infant up to one year of age in Georgia).

Our knowledge of the problem relating to child health comes in large part from our participation on the Council where for one year we surveyed and studied all tax-supported health programs providing services to the children and youth of Georgia.

This paper is being submitted as INDIVIDUALS concerned about, and advocates for, the infants, children and the youth of this country.

During the course of data gathering and analysis

numerous individuals were contacted for assistance and information. Among those contacted were practicing pediatricians in the private and public sector; pediatric educators; administrators of federal and state agencies providing services to children and youth; the office of Child Health Affairs, Office of the Assistant Secretary for the Department of Health, Education and Welfare; The National Institute of Child Health and Human Development (NICHD), National Institutes of Health (NIH); the Office of Maternal and Child Health, Bureaus of Community Health Services; American Society of Pediatrics; Representatives of the American Academy Pediatrics; voluntary organizations and private citizens.

Without exception every individual contacted identified as the most critical problem the proliferation, multiplicity and diffusion of maternal and child health programs among numerous agencies of the federal government in the absence of a strong maternal and child health administrative unit.

In his presidential address to the American Pediatric Society on April 28, 1976, Edward Pratt, M.D., eloquently described the problem. (A copy of his address is attached.) This group of physicians supports without equivocation Dr. Pratt's admonition that:

> "Children are the only group who accept being cheated with equanimity. The record shows unequivocally that politicians and agency administrators have accepted this formula and have acted accordingly. It is easy and politically

> safe to manipulate a powerless, unorganized, non-voting group such as children, especially children of the poor."

A detailed statement of the problems and data is felt to be unnecessary in view of the profuse amounts of information available in current publications.

However, data recently published by The National Foundation - March of Dimes is worthy of mention:

> "45,000 Americans were killed on highways BUT 53,000 infants died before their first birthday during the same time period.
>
> 1,200,000 children and adults are hospitalized annually for treatment of birth defects."

The recommendations which follow are based upon the premise that:

1.) The child is a product of, and must be considered in the context of, a family unit.

2.) The time has come for America to reorder its priorities and meet the needs of forty percent of its population (those under the age of twenty-one) and provide them with every opportunity to become healthy, responsible and productive adults.

3.) The national goal must be that every child have access to primary health services from conception to age twenty-one.

4.) Preventive health programs must have the

highest priority.

5.) Research into causes of reproductive wastage, birth defects and acquired physical and mental conditions and learning disabilities must be given greater emphasis.

6.) There is a need to strengthen the existing federal health care programs, through strong leadership, and to examine and modify the basic health legislation and its administrative structure to meet the needs of the maternal and child health population.

7.) A single standard of quality for medical care be established for all children and pregnant women regardless of family income.

RECOMMENDATIONS:

I. Federal Agency for Maternal and Child Health

The single most critical need to resolve existing maternal and child health problems is the creation of a strong central agency. This agency should be headed by an Administrator for Maternal and Child Health, appointed by the President.

The agency should have authority to:

(a). Direct, coordinate, monitor and review all maternal and child health programs.

(b). Assist and implement the recommendations of the proposed advisory council.

(c). Make recommendations to assure non-competitive allocation of funds for maternal and child health programs.

(d). Serve as an advocate for maternal and child health in the development and implementation of PL 93-641, (Health Systems Agency) and other comprehensive federal health programs.

(e). Develop national health programs for mothers and children responsive to the national health policy adopted by the proposed advisory council.

(f). Coordinate its efforts in health service with the National Institute of Child Health and Human Development.

II. National Advisory Council for Maternal and Child Health.

Legal authority is provided to the Secretary of DHEW to establish specialized councils in Section 1114(f) of the Social Security Act. The Secretary should be authorized to appoint an advisory council as soon as possible.

The membership should include broad representation of a) health providers of services to mothers and children, b) appropriate professional associations, c) consumer representation, d) appropriate representatives of the National Institute of Child Health. and the National Institute of Mental Health. Additionally there should be reciprocal representation between the proposed council and the Domestic Council of the White House.

The proposed council's responsibilities should include, but not be limited to:

(a). Development of a national health policy which recognizes and considers the significance of lifestyle, nutrition, environment and education upon the development of healthy mothers and children.

(b). Development of a single standard of quality of medical care for all children and pregnant women regardless of family income.

(c). Specify maternal and child health priorities including a proposed time table for implementation.

(d). Study existing maternal and child health programs and projects funded by the federal government and make recommendations for maximum consolidation and coordination. The ultimate objective must be an efficient non-fragmented delivery system at the

grass roots level which is responsive to the needs of mothers and children.

(e). Establish mechanisms to provide for continuing reviews and evaluations of operational programs for cost effectiveness, and impact upon the quality of life.

III. Interim Priorities

While the proposed agency and council are being established the following programs require immediate attention and restoration of required funding levels.

A. Maternal and Child Health Programs

The programs authorized by Title V of the Social Security Act, e.g., Maternal and Child Health, Crippled Children's Services, project funds for Maternal and Infant Care, Intensive Infant Care, Children and Youth Services and Dental Services, as currently operating are providing a vital service. There should be an immediate increase in funding level in order to provide services to the greatest number of eligible recipients until this legislation is reviewed in depth by the proposed council.

B. Nutrition

The WIC Program should be made an entitlement program to assure its maximum utilization by eligible women, infants and children who

are now excluded due to budget and geographical limitations.

C. Immunization

The Center for Disease Control published data indicates that a large segment of child population is unprotected from preventable communicable diseases. Therefore there should be an immediate restoration of funds to the program

D. EPSDT (Title XIX), Title XX, Head Start, Developmental Disabilities, Sickle Cell, Lead Based Poisoning Acts and Titles I and the Title 45 Amendment of the Elementary and Secondary Education Acts.

Our concerns were reinforced by a recently approved report submitted by an Ad Hoc Committee to the Executive Board of the American Academy of Pediatrics relating to Title V Projects. We quote:

> A primary problem shared by all programs is the fragmentation of effort with resultant gaps and inefficiency. The aforementioned acts are representative of incompletely developed approaches to meet needs of mothers and children. Without exception they either fail to be identified with a system of health care delivery or they prompt the development of additional piecemeal systems. The effect is that they promise more than they can deliver or act as divisive efforts in a community by competing for inadequate manpower and facility resources.

The proposed designated federal agency and its advisory council, as a first priority, should study the Title V legislation in relation to other existing programs. The result should be the consolidation of the best of these into a single, comprehensive maternal and child health act responsive to the needs of today.

E. Research

Research is the process by which new knowledge is accumulated which can then be applied to prevention of disease and advancement of health. Research into the problems of mothers and children has the greatest long term implication of all health research. It can answer questions which have an effect over the entire life span and enhance the quality of life. Development of preventive health programs will be increased and appropriations for treatment programs will continue to escalate until the causes of reproductive wastage, birth defects, and developmental diseases, including learning and aberrant behavior are known. Consequently, it is imperative that there exist within the Federal government a well funded, central agency responsible for conducting and evaluating all research, basic and applied, aimed at the betterment of health care of mothers and children.

The NICHD within the National Institutes of Health is now the major source of any information concerned with health of mothers and children.

The NICHD:

a.) Should be officially designated the health agency for the development of all research activities relative to mothers and children;

b.) Should remain in the NIH where it can interrelate to other biomedical and behavioral research programs, and thus develop coordinated efforts;

c.) Should receive, incremental to its official funding, via the NIH, and additional amount equal to a surcharge of 10% of the funds designated annually for health services to be used for initiating and innovating new approaches for research, development, and training in maternal and child health;

d.) Serve ex officio on the proposed advisory council to the administration of maternal and child health.

These steps are made to insure an adequate national research and training effort aimed at mothers and children.

Advances made here will prevent disease and disability in the adult and thus provide the

greatest cost ratio benefit of any form of research.

F. Maintaining Existing Preventive Health Services

There has been a consistent reduction in the level of appropriation which, when considered in context of the inflationary spiral that exists, has forced program administrators to provide less services to fewer people in need.

Programs which have been cut are those providing maternal and child, family planning, immunization, dental and nutritional services.

These programs that are available must receive an adequate continuing level of funding and research funds must be allocated to identify other effective preventive health services.

In addition, community leaders should be encouraged to re-emphasize, promote and restore the many excellent youth programs sponsored and supported by private organizations which have played a vital role for generations in the development of the youth of America.

G. Legislative Moratorium

Ideally we would like to see a moratorium on pending maternal and child health legislation but we know this is not possible.

The passage of legislation in process, although well intended

will add to the existing stockpile of fragmented programs described.

It is hoped that the next administration will designate the proposed maternal and child health agency and advisory council as the responsible agency for developing a comprehensive and effective maternal and child health program.

H. Pluralistic Approach

Programs and services which must be delivered in the private and public sectors of health care must include broad representation of those at the grass roots level in the planning process.

This representation must be incorporated into the entire process beginning with the writing of the legislation and proceeding through the development of the regulatory mechanisms.

IV. Suggestions for Reorganization

Chart 1 visualizes with clarity the current state of diffusion of maternal and child health programs with in DHEW.

High priority should be given to initiating a study to determine which program components relating to mothers and children could and should be consolidated under the proposed single administrative unit.

Chart 2 is a partial list of the programs which,

with limited time for study, have been identified as inter-related, have similar objectives and lend themselves to consolidation.

A decision to consolidate these programs would eliminate the Office of Child Health Affairs; the Office of the Assistant Secretary for Human Development; the office of Maternal and Child Health in the Health Services Administration and other offices and agencies will be reduced by that portion which relates to children.

It would appear that without additional funds, with perhaps a shift in monies; duplication can be largely eliminated and intelligent planning for a system of maternal and child services become a reality.

V. National Health Insurance

The development of a health insurance system has begun through Medicare for the elderly and disabled, Medicaid for the poor, federal and state programs of categorical service and through employee group insurance plans. Many barriers exist to high quality comprehensive health care for a significant segment of the maternal and child health population. This high quality care needs to be distinctive, and preventive services should have the highest priorities.

Mothers and children should have available some form of payment for health care which meets national standards. It would seem advisable to establish a specific annual gross income eligibility level, e.g.

$20,000.00 in order to avoid the expense entailed in monitoring complicated eligibility requirements. It is estimated that the current cost of monitoring Medicaid eligibility alone is 400-500 million dollars annually.

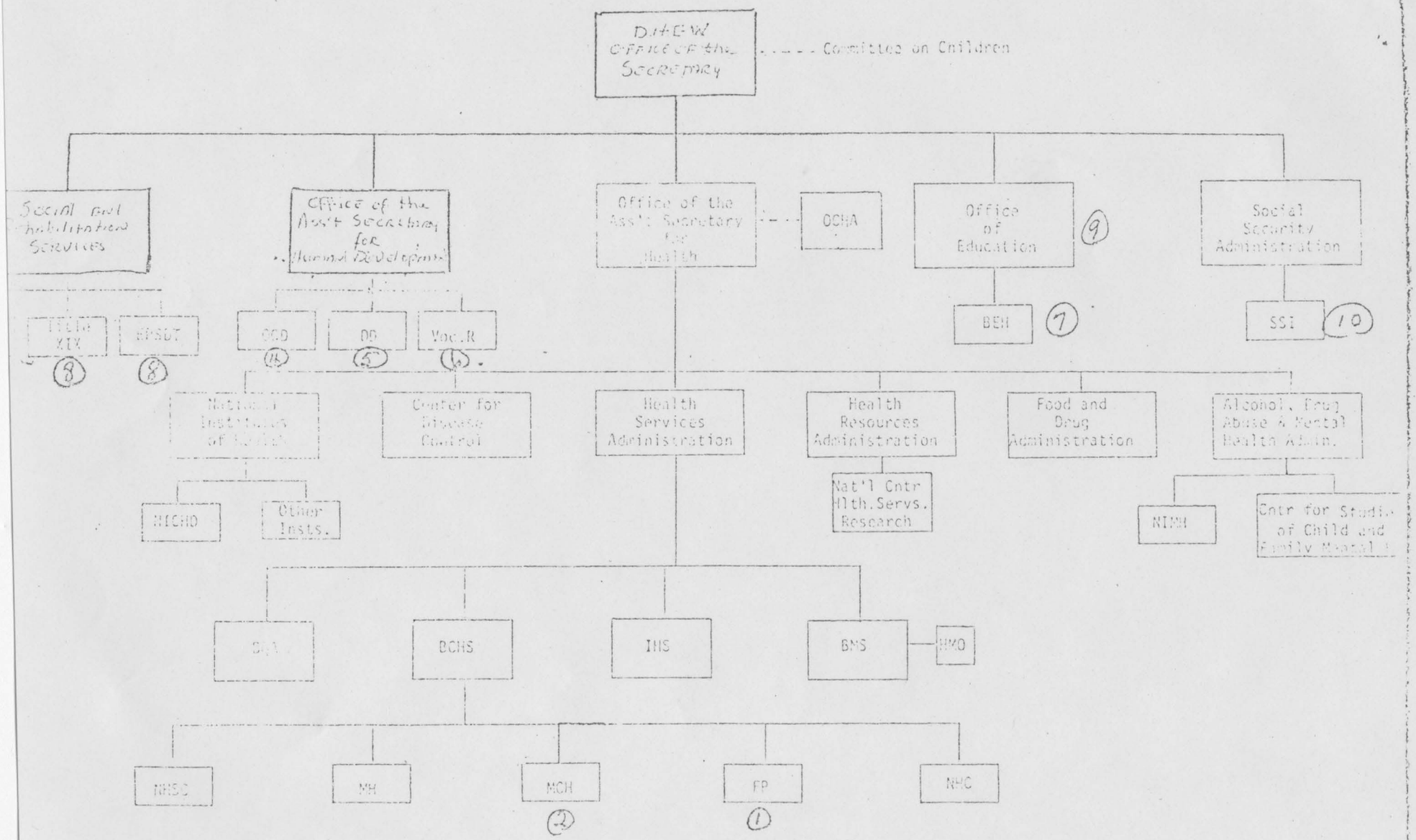
The Council is aware of and plans to study S 3593 and has reviewed in depth, H 12937 shortly after its initial publication.

VI. Other Concerns

Mental health services for mothers and children should be incorporated into the proposed agency for maternal and child health. This important aspect of maternal and child health has not been included in the activities of the Advisory Council on the Physical Health Needs of Children and Youth and therefore, has not recieved the attention it deserves.

In administratively restructuring programs for mothers and children as described it should be noted that similar recommendations and organizational realignment is equally applicable to the services related to aging. Chart 2 places the newly created agency for aging in the Office of the Assistant Secretary for Health.

CHART I



11, 12, 13 - Locations not shown

CHART 2

Assistant Secretary for Health

HRA | NIH | Agency for Maternal & Child Health | Agency for Aging | CDC | FDA | ADAMHA

Agency for Maternal & Child Health

Maternal & Child Portions of:

1. Title X - Family Planning
2. Title V, Social Security Act Maternal & Child Health
3. Title XX -
4. Office of Child Develop. Head Start, etc.
5. Developmental Disabilities
6. Vocational Rehabilitation
7. Title I and Title 45
8. SRS, Title XIX Medical Assistance Program EPSDT
9. Office of Education - PL 94-142 Early Diagnosis of Learning Disorders
10. Supplementary Income for Children (SSI)
11. Champus
12. Appalachian Regional Commission
13. WIC

The most important product of this country is a wanted child who is well born and healthy. Thus, our emphasis, as the advocate for mothers and their progeny, must begin with conception.

Problem

There are 47 million women of childbearing age and 64 million children under age 18 in the United States -- a total which is more than half the population of the United States.

Our country has no national health policy, and existing circumstances portend none. Federally supported health programs for mothers and children -- presumed to be directed at important needs -- are scattered throughout HEW and the Departments of Agriculture, Labor, Defense, State and probably others. Also involved at the federal level are White House committees, boards, agencies, and quasi-governmental groups.

Objective

The main objective is to reduce perinatal mortality and morbidity in the United States to an irreducible minimum. To accomplish this a national program should:

. Focus on important basic and clinical research.

. Translate research into improved patient care.

. Coordinate federal efforts at improved patient care.

Essentials of Health Care

One of the essentials to assure a healthy generation is medical services that are based on one standard of care for all and include

1. Family planning
2. Total obstetric care, including prenatal, intrapartum, and postpartum care, with special emphasis on the high risk mother and fetus.
3. Newborn care from the moment of birth.

Other essentials to be addressed are adequate nutrition and education. The best medical care available cannot overcome the handicap of inadequate nutrition and educational deprivation.

In any program of national health care, it is important that the quality of that care not be sacrificed by reason of cost, and that services should be reviewed by qualified specialists to assure that services are medically necessary, of high quality, and provided in the appropriate setting for optimum patient care.

The regionalized concept of perinatal care has the greatest potential for assuring the highest quality of care to the mother and newborn, while at the same time may be the most cost effective.

Education/Research

Any national health program must provide for adequate education and research. Progress in medical care is dependent upon adequate programs of basic and clinical research. Knowledge obtained by research programs must be developed into suitable mechanisms for clinical utilization in the care of patients.

The funding of education and of research and development related to health care should be established upon a consistent basis, with costs distributed equitably among the population as a whole, and discrete from patient services.

Recommendations:

- Strengthen federal coordination and decision-making capability.
- Office of Maternal and Child Health in HEW, with appropriate authority.
- Strengthen MCH staff and identification at the national level.
- Advisory groups for clinical application of basic and clinical research.
- Support of clinical and applied research, both biomedical and social.
- Data banks on specific entities, but avoidance of categorical fragmentation by special interest groups.
- National guidelines for HSAs as they relate to the provision of maternal and child health.
- Major priorities that are long-term and not changed yearly.
- Coordination and cooperation between federal administrative offices and representative professional organizations in:
    1. Regulatory rule-making.
    2. Public announcements affecting health care.
    3. Program implementation.
    4. Evaluation of program accomplishments as related to legislative intent.

The American College of Obstetricians and Gynecologists

8.24.76

APPENDIX A

M.C.H. PHILOSOPHY

WE EXPERIENCE THE BIRTH PROCESS ONLY ONCE IN OUR LIFETIME.....

HEALTH AS AN INVESTMENT*

For a long time, economists have been in the business of attaching dollar figures to human life.** With the great rise in the popularity of cost-benefit analysis as an aid to government decisionmaking, economists have applied their experience in valuing life to measuring benefits from programs that reduce disability and improve health. The concept of valuation of life generally used to estimate the benefits of desease reduction is the "human capital" concept. This concept views a human being as a productive asset, one who will generate a stream of earnings through future years. Capitalizing these future earnings at some appropriate interest rate allows one to attach a capital value to an individual. By analogy with the theory of investment in physical capital, any investment which raises the capital value of a human being by more than the cost of the investment is worth undertaking.

I. THE PROBLEM

Available evidence confirms that in order for an individual to achieve optimal potential, mothers and children must be brought into the mainstream of health care.

The problems of mother and children are unique in that by giving the highest priority to preventive health care one will greatly reduce the incidence of acute care treatment and possibly lifelong disabling conditions.

*Reference: Vincent Taylor, The Rand Corporation, Santa Monica, California

** For a historical review of efforts to calculate the value of human lives, see Dublin and Lotka (1).

The usual indices of health status will not be significantly altered until preventive health services receive an appreciably higher priority than they now enjoy.

Many obstacles are thrown into the path of infants, children, youth, and pregnant women as they seek access to services to meet their needs, especially those without resources to purchase care (Tables I and II).

The specific barriers to be addressed are those created by federally mandated health programs.

These barriers deny mothers and children access to a uniform standard of quality health care. A brief description of the barriers by sites of occurrence follows:

FEDERAL LEVEL

The Executive and Legislative branches of federal government must support the development of a National Maternal and Child Health Policy directed toward reducing maternal and infant morbidity and mortality and improving the quality of life for generations to come.

A fundamental principle within such a policy should be equal access to appropriate care for all pregnant women, infants, and children. This means that health resources must be developed to overcome the social, geographic, and financial barriers to health care which exists in far too many areas.

The proliferation, duplication and diffusion of health legislation has contributed to the less that expected rate of improvement in health status. Failure to recognize, utilize, and update the capability inherent in the original intent of Title V of the Social Security Ammendment has resulted in diffusion of programs (fifteen or more DHEW agencies), enactment of categorically limited legislation (Titles V, X, XIX, XX and Titles I and 45 of the Elementary and Secondary Education Acts).

STATE LEVEL

Recent national health legislation executive actions has created new health responsibilities for state governments without commensurate state funding and without mechanism for participation by state agencies in the formation of these new programs.

As a result, state governments are:

1. Implementors of federal programs with insufficient participation in their development.

2. Conduits for the disbursement of federal health dollars.

3. Utilizing increasingly higher percentage of available state funds to meet federal matching requirements.

4. Initiating fewer state planned health programs.

5. Forced to reduce services to the working poor and medically indigent as a result of #3.

6. Places in a position of responding to federal priorities, mandates programmatic ambiguities, and revisions often with insufficient time and increasingly more penalties.

7. Compromised by withdrawal of Federal Staff suppor of state maternal and child health programs.

COMMUNITY LEVEL

The major problems of access and availability are most evident as the individual attempts entry into the health care delivery system.

Barriers include, but are not limited to:

1. Commercial Insurance Deficits

   In all but a few states, commercial insurance does not provide universal comprehensive maternal and newborn health insurance.

   Notably absent are provisions for periodic preventive health maintenance examinations, as well as, coverage for catastrophic events for the mother, fetus, and infants.

2. Unequal Standards of Health Care.

   The working poor and medically indigent are ineligible for government supported health services.

   a. are often provided with individual insurance coverage while their higher paid co-workers are offered family coverage by employers.

   b. are forced to enter the health care system for care of acute conditions, e.g. obstetrical patients present themselves for the first time at a hospital at the time of delivery; children enter for treatment only for episodic, cricis oriented stuations.

   c. this large group of citizens seldom receive dental care, correction of visual defects, or preventive health care including family planning.

3. Access Limitations.

   a. Those individuals eligible for Medicaid Services have problems of a different nature, e.g.

Increasing numbers of physicians, dentists, and other providers are not renewing their provider contracts, forcing recipients to travel long distances for treatment services. Among the reasons given for not renewing Medicaid contracts are administrative costs, conditional reimbursement machanisms and frequent revisions in rules and regulations.

In 27 states, primiparas are not eligible for AFDC benefits because the fetus is not considered a dependent child.

b. Resource Deficits

Those service agencies at the community level have felt the greatest impact of the proliferation of health programs.

Often these agencies are without sufficient resources, especially professional and clerical manpower to perform the tasks mandated by the rules and regulations accompanying each program.

c. Recipient Resistance

Those citizens eligible for government supported services often lack the understanding and motivation to seek care for potentially disabling conditions, follow prescribed treatment regimens and continue care until the health problem is resolved.

In order to achieve maximum recipient response to seek needed services various approaches must be initiated which will raise the recipient's motivational level to seek help.

II. JUSTIFICATION FOR FEDERAL ACTION

The problems as described are multifocal and occur at the Federal, State, and Community levels, and therefore require reorganization and development of a National Maternal and Child Health Policy.

The victims of these bureaucratic barriers are the potential recipients in need of services. Some examples are:

1. Government Assistance Beneficiaries.

Individuals eligible for assistance from multiple programs often face delays in entering the system while agencies settle territorial disputes. AFDC recipients frequently face this problem.

2. Medically Indigent

The working poor are the real victims. At each point of entry they face rejection when the civil servants or private sector learns they do not meet rigid program eligibility requirements even with identical handicapping, catastrophic conditions.

a. The young couple, whose annual income is $15,000, learns their insurance excludes high risk obstetric and prolonged neonatal care which could well exceed their total annual income.

b. A family of four, with an annual income of $8,000 with or without health insurance, is unable to purchase private preventive health services and is ineligible for others.

Federal action should seek to convert our present inadequate, fragmented programs into a comprehensive coordinated approach aimed at the establishment of a single standard of quality health care for mothers and children.

The consolidation and coordination of existing legislative programs under the proposed Maternal and Child Health Administration could consider the reassignment of the functions of the following offices of DHEW currently charged with the management of diverse programs bearing upon Maternal and Child Health.

a. The Committee on Children, Office of the Secretary of DHEW

b. Office of the Assistant Secretary for Health, Office of Child Health Affairs.

c. Office of Assistant Secretary for Human Development, The Offices of Child Health and Developmental Disabilities with realignment of Vocational Rehabilitation.

d. Health Service Administration -
Bureau Community Health Services, The Office of Maternal-Child Health and Family Planning.

e. Office of Education
Bureau of Education for the Handicapped - PL 94-142 - Early Diagnosis of Learning Disabilities and Title 45 Amendment.

Consider Reassignment of the maternal and child health portions of

a. Social Rehabilitation Services
That portion of Title XIX, EPSDT and Title XX which established service provisions.

b. Social Security Administration - Supplemental Security Income.

c. Appalachian Regional Commission - Maternal and Child Health projects.

d. Alchohol, Drug Abuse, and Mental Health Administration.

It is not inconceivable that other programs and appropriations scattered throughout the agencies of government would lend themselves to consolidation and coordination under the proposed Administration.

A period of study of existing program provisions and the development of a national maternal and child health policy is prerequisite to a cohesive comprehensive maternal and child health program which will meet the health needs of half of the total population. These functions can best be achieved through the establishment of a Maternal and Child Health Administration.

III. PROS AND CONS OF PROPOSED OPTIONS

Three options are offered for consideration:

A. Continue existing organizational structure.

B. Early National Health Insurance (NHI).

C. Maternal and Child Health Administration (MCHA)

A. Continue Existing Organizational Structure

The adoption of this option would:

require little or no administrative reorganization.

provide children up to 21 years of age and mothers (in theory) with access to services.

assure recipients and providers of the continued freedom of choice they now have.

not improve health status.

further reduce quality of care.

preclude a uniform standard of care.

escalate administrative costs.

raise federal, state and local taxes.

perpetuate program underfunding.

continue to exclude a large economically eligible population from service.

perpetuate ineffective health service programs.

require additional employees at all levels.

B. Early National Health Insurance Legislation (NHI)

A decision to encourage the early passage of maternal and child health insurance legislation as the option of preference will in all probability:

Assure comprehensive health insurance coverage to all children up to 21 years of age and pregnant women.

Increase the probability that mothers and children are guaranteed entry into the health care delivery system.

Vastly increase the demand of all health services immediately.

Create massive delays in gaining entry to the system for treatment of chronic, pre-existing conditions and preventive health services.

Increase the use of automated systems which could effect the traditional physician-patient relationship.

Cause unanticipated alterations in the existing systems with no predictable assurance of improvements.

Provide insufficient time for administrative and provider organization and planning prior to implementation.

Increase opportunity for additional levels of bureaucracy and increased response time to recipients and providers.

Require revision, consolidation, reorganization and termination of direct services.

Alter personnel requirements to administer the program, e.g., increase clerical and decrease professional staff except at provider level.

Eventually may alter an individual's freedom to select a provider.

Eventually may alter a provider's freedom to select a patient and area of practice.

C. Maternal and Child Health Administration

This third option has been extensively described in the previouly submitted position paper and referred to in earlier sections of this appendix. The establishment of a Maternal and Child Health Administration should receive the highest priority.

IV. POTENTIAL OPPOSITION AND SUPPORT

In the form that the proposal is submitted the intent and the effect should be to provide for elimination of fragmented programs and pooling the expenditures already being made into more effective programs. Implementation of a National Health Policy by the Administration may raise costs initially, however, the long term result should be cost beneficial.

Opposition may be expected from some of those agencies that will be involved in such a reorganization who would view this proposal as a threat to their existence. This concern should be real only if those agencies or those individuals feel that the mothers and children are the secondary reason for their existence.

Opposition could arise from physicians and other providers which may not recognize the long term and universal benefits of meeting the needs of mothers and children.

The support for this proposal might be expected to come from those professional organizations whos members are already attempting to cope with these needs of mothers and children on a day-to-day basis.

Additional support should be expected from the many volunteer maternal and child advocacy organizations such as The National Foundation-March of Dimes, The Association for Retarded Citizens, The Muscular Dystrophy Foundation, The Cystic Fibrosis Foundation, The Hemophilia Society, The American Diabetes Association, and the hundreds of lay citizens' volunteer organizations throughout the nation.

TABLE I. MATERNAL AND CHILD POPULATION

(1) Children

Age Group	Number
0 to 6	20,000,000
6 to 12	22,000,000
12 to 18	25,000,000
	67,000,000

(2) Maternal

3,000,000 births/year (3 million mothers)

(3) Of the 24.3 million persons with income below the poverty line 19.4 million live in families and 4.9 million are unrelated individuals.

It is estimated that of the 25.6 million persons receiving medical benefits in 1976, 11.7 million persons will be children under age 21 and 7.2 million will be adults in AFDC. (Source: Special analysis: Budget of the U.S. Government, fiscal year 1976, p. 184.)

TABLE II. NUMBER AND PERCENT OF CHILDREN IN FAMILIES WITH INCOMES BELOW THE POVERTY LINE, 1974

Related Children by Size of Family	Number of Children Below Poverty Line	Percent of All Children Below Poverty Level
All Children Under 18	10,196,000	15.5
In 2-Person Families	582,000	38.0
" 3-Person "	1,310,000	14.3
" 4-Person "	1,827,000	10.1
" 5-Person "	1,861,000	11.9
" 6-Person "	1,565,000	15.9
" 7-Person or more person families	3,050,000	26.3

Lowest Poverty Incidence: Male head, white, 4-person family = 4.0%

Highest Poverty Incidence: Female head, black, 5-person family = 74.8%

Source: Characteristics of the Population Below the Poverty Level, 1974

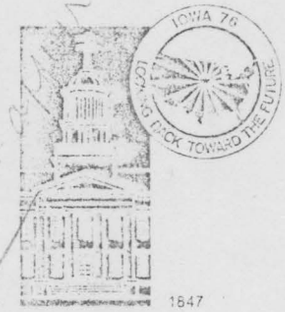
Current Population Reports, Consumer, Income, p. 60, No. 102, January, 1976.

U.S. Department of Commerce, Bureau of the Census, Table 22, p. 88.

The University of Iowa
Iowa City, Iowa 52242

University of Iowa Hospitals and Clinics
Department of Pediatrics

(319) 356-2295
If no answer, 356-1616



DATE: September 3, 1976

TO: Members of the "Atlanta Committee"

FROM: John C. MacQueen, M.D.

RE: Position Paper on Maternal and Child Health

It is my opinion that our "Atlanta Committee" provided Governor Carter's staff with a helpful background paper and identified people and organizations that would be available to provide more information.

However, we did not provide his staff with a political statement about the importance of health services for the mothers and children that could be used in the campaign. More importantly, we did not provide Governor Carter with a list of objectives that we would want him to implement during his administration.

I believe that we should provide Governor Carter's staff with an imaginative charter for mothers and children that includes issues we discussed at the time of our Atlanta meeting. For this reason, I wrote the enclosed statement that lists most of the ideas that we discussed.

I would have preferred to be able to put it aside for a week and then to have rewritten it before I sent it to you, but time does not permit. Therefore, I send this draft copy to you requesting that you edit, add, or delete. When you return your suggestions, I will combine your ideas and rewrite the paper.

It would have been far better if I could have "farmed out" each of the objectives to appropriate members of the committee with the request that they develop a supporting statement for the objective. Such an arrangement would certainly have increased the quality of the statement. Time does not allow us to do this. Furthermore, I believe the supporting material for the list of objectives was included in the material sent to Mr. Carter's office before the meeting and from the Committee's paper.

Responsibility of authorship creates a problem.

I am aware that not all members of the "Atlanta Committee" are in agreement with the list of objectives; therefore, the position paper should not be credited to any person or organization or to the "Atlanta Committee." It

can only be a paper put together by recognized experts in the field of maternal and child health. In effect, it is a list of commonly stated objectives for maternal and child health from which Mr. Carter and his associates can select their own list of objectives on the basis of his basic policies.

The time is very short. I ask that you limit your editing time to three days and return it to me. If you believe the basic idea is in error and prefer not to participate, that's fine--there will be no hard feelings.

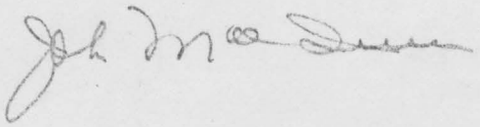
JCM:ck
Enclosure.

Dear Erv:

This effort puts me on thin ice but I believe that such a statement is needed if we are to be effective in the political arena.

I would ask that you particularly check the terminology in the objectives concerned with maternal services.

I enclose a copy of my proposed letter to Mr. Jack Watson to show you how I propose to handle the matter of responsibility.



The health of this nation's future citizens will be determined by the health of today's mothers and children.

As the nation provides services to insure the health of these two groups, it insures the health of the nation's future adult population. Therefore, health services for mothers and children represent the best investment the nation can make in health.

The majority of the services required by mothers and children are basic health services and are relatively inexpensive, but some of the services are complicated for they are needed to solve complex modern maternal and child health problems and these will test the determination of the nation.

The following national goal and objectives are proposed-

- The goal of the nation shall be that each mother is healthy, that each child is wanted, and that each child is healthy and able to achieve his/her optimal development.

To respond to this goal, the nation must be certain that-

- Each woman will have access to inter-conceptional services that are needed to insure her health and the health of the fetus.
- Each woman will have access to modern prenatal, natal, and postnatal care.
- The cost of obstetrical care must not be a barrier for any child-bearing mother from receiving complete obstetrical services.
- Any child born at risk will have access to modern specialized care.
- Health care for children up to six years of age will be available without regard to family income.
- Any child born with a disability will have access to an individualized program of care as needed to result in optimal habilitation.
- All children will have access to approved immunization procedures to achieve a national objective of eradicating the communicable childhood diseases that are a major cause of disability.

- The nation's major and increasing problem of teenage pregnancies must be met with a total national effort.

At this time of decreasing family size, this nation has a moral responsibility to reaffirm:

- its recognition of the dignity of child-bearing,
- the importance of mothering, and
- its commitment to provide needed child health services for children.

To do this, the nation must develop a contemporary national program of maternal and child health services.

OR

To do this the President will provide leadership in the development of a contemporary national program of maternal and child health services.

Mr. Jack Watson, Jr.
King & Spaulding
2500 Trust Company Tower
Atlanta, Georgia 30309

Dear Mr. Watson:

A group of recognized national leaders in the field of maternal and child health met in Atlanta on August 25 and 26 and provided your office with a background paper.

In an effort to provide your office with a more concisely stated position paper about the issues relating to improving maternal and child health, the enclosed position paper was drawn up.

In the field of human services and certainly in the field of health, there is complete agreement about almost no issue. As professionals, we are reluctant to answer our questions by vote. However, the enclosed position paper is the consensus of many informed and responsible people concerned with maternal and child health. It is a statement that would have broad national support among a number of organizations and groups that are very concerned with the current low status of services for mothers and children.

There is no implication that the goal or objectives need to be used as stated, nor is it assumed that all the objectives will be used. The paper is presented to provide Governor Carter with important ideas written by people qualified in the field. We are aware that political reality may require them to be rewritten.

The national leaders in the field of maternal and child health who developed this position paper sincerely request that Governor Carter give serious consideration to it, not only as an attractive campaign issue but as an issue of major importance for his administration.

Respectfully,

(Please indicate if you wish to have your name included on the letter to Mr. Watson as a contributor.)