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cc: Quern
Johnson



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
WASHINGTON, D.C. 20201

OFFICE OF THE SECRETARY

SEP 1 1976

Health

The Honorable James M. Cannon
Director
The Domestic Council
The White House
Washington, D.C. 20500

Dear Mr. Cannon:

Secretary Mathews asked me to send you a copy of his statement on Medicaid together with information he released at a major news conference on fraud and abuse held last March. All of this data was made available to the press yesterday.



Sincerely,

Sanford H. Winston
Sanford H. Winston
Executive Assistant
to the Secretary

Attachment

file

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THE WHITE HOUSE
WASHINGTON

September 1, 1976

MEMO TO: JIM CANNON
FROM: ALLEN MOORE *AM*
SUBJECT: President's record on Medicaid.

*Allen -
Thanks,
Jim*

The 1965 Amendments to the Kerr-Mills bill created both the Medicare and Medicaid programs. The President voted against the entire package on three separate votes. There are no statements attributable to him on the subject in the standard references.

You may recall that in 1965 there was strong opposition to these programs as precursors to "socialized medicine." Organized medicine fought the legislation and many people supported the AMA position on philosophical grounds.



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THE WHITE HOUSE
WASHINGTON

September 7, 1976

File
MISSOURI

MEMORANDUM FOR:

ART QUERN

FROM:

SARAH MASSENGALE

SM



This morning you inquired about the status of a request from a Missouri group to be designated a regional cancer center.

Missouri Cancer Program Inc., a consortium of private, non-profit groups (including the State Health Department, the University of Missouri and 4-5 schools of osteopathy), was formed by John Yarboro a former National Cancer Institute (NCI) employee, for the purpose of establishing a state-wide cancer program. Last winter HEW awarded the consortium a cancer center support grant to help build a state-wide cancer facility.

The consortium has now applied to NCI to be designated a comprehensive cancer center for Missouri. HEW has scheduled a site visit for Monday, October 11. A recommendation should be submitted to the National Cancer Advisory Board Subcommittee on sites and centers by at least January and to Dr. Rauscher by February or March. At that time it will be decided whether to recognize the center as a comprehensive one.

Apparently there has been a bit of in-house squabbling in Missouri over this one; HEW has tried to stay clear of it.

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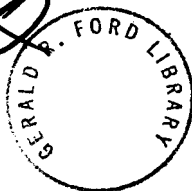
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15-18 mos. FOR CONCEPTUAL DEVEL

THE WHITE HOUSE
WASHINGTON

Jim Cannon
Thanks

AGS



CBS

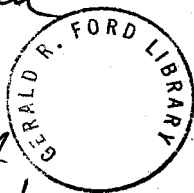
Tuesday, Sept. 7

Jim -

Here are copies of
those Moss booklets

I mentioned to you
last week.

Best,
Joe



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8/30/76

File
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Health

MUDD: Senator Frank Moss, who's been heading a Congressional investigation of Medicaid fraud, today criticized the Health, Education and Welfare Department for what he called, "singularly unimpressive" efforts to stop the abuses. HEW Secretary David Mathews responded Senator Moss was "grandstanding". More on the story from Robert Schakne.

ROBERT SCHAKNE: It was a moment of carefully orchestrated drama: Senate staff-members displaying 250 prescriptions for medicine from so-called Medicaid mills - medicine that was given to healthy Senate investigators who were posing as patients for treatment of diseases they did not have. The point was to show a pattern of bad treatment or outright fraud in Medicaid. In terms of headline-attracting revelations, the three days of hearings into Medicaid fraud are among the best of the Capitol Hill events of the season. One event starred subcommittee chairman Frank Moss as a Medicaid patient, filmed after he sought treatment at an East Harlem Medicaid mill last June seventh - treatment he says was terrible.

SEN. FRANK MOSS [Subcommittee chairman]: If you're not sick, you won't be told you're not sick. If you are sick, the odds are you won't be helped. In the last analysis, the best description is the one given to us by a mill owner, who said, "Medicaid isn't medicine, it's business. Curing patients is good medicine, but bad business."

SCHAKNE: Five committee investigators, including two Capitol Hill policemen, testified about posing as patients in Medicaid mills - being referred unnecessarily from doctor to doctor, with each one then charging a fee. And they told of fictitious diagnoses.



JAMES ROBERTS, JR. [Capitol Hill policeman]: The podiatrists I saw were also prone to order X-rays for questionable reasons. One told me that I had a bunion on the big toe of my right foot. Another told me I had a bunion on the big toe of my left foot. Both said they had to take X-rays to make sure.

SCHAKNE: As the committee staff told it, Medicaid mills, the privately-owned, profit-making health centers in ghetto neighborhoods, skim off from 50-to-70 percent of the Medicaid dollar through excessive rents, kickbacks, fee-splitting and outright fraud. The committee report said the worst abuse was to be found in New York City. The Committee staff says total Medicaid mill fraud and waste nation-wide amount to over \$1-billion a year. In the view of a lot of experts, the evidence and statistics don't back up that claim, but there is no argument that the poor, the people that Medicaid is supposed to help, are not getting the care that the country is paying for.

—Robert Schakne, CBS News, Washington.

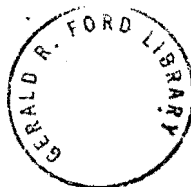
MUDD: A Federal judge today found that the Cleveland school board deliberately created a segregated school system, and that the Ohio education board took a "do-nothing" attitude. The judge ordered the city board to submit a desegregation plan within 90 days. The Cleveland school system has 127,000 pupils, of which almost 60 percent are black.

MUDD: A witness convicted of Medicaid fraud told the Congress today that Medicaid invites abuse because a doctor is paid for each patient visit, no matter how brief or simple the treatment. "It's a polluted system," said Dr. Joseph Ingber, "and every doctor who sets foot in it runs the risk of having his professional standards degraded." More on the story from Robert Schakne.

ROBERT SCHAKNE: The principal witnesses on the second and final day of the hearings included those who owned and those who worked in Medicaid mills. Doctor Nancy Kurke, employed in a Brooklyn Medicaid mill for six months, said the quality of care was so bad that a man with an advanced case of cancer of the mouth had gone untreated at the Medicaid mill for two years.

DR. NANCY KURKE [former Medicaid physician]: No one had looked in his mouth. No one cared to know. It wasn't worth the trouble to take the time to look in his mouth because you don't get paid for that. It's a waste of time. Anything you do that you can't put down is a waste of time.

SCHAKNE: Two chiropractors who once owned eight Medicaid mills, and who have each just been given five-year prison terms for fraud, testified that the basic system was wrong, that it invited thievery.



JOSEPH INGBER [convicted chiropractor]: The only way to stop the system is not to try and shore-up a weak foundation. It's to start over again. This system stinks. But the only way to stop this is to not pay for the number of visits, but the number of people. And then, the exact opposite will happen. No doctor will encourage extra visits because he's not getting paid by the visit. He's getting paid by the number of patients in a given community in a given period of time.

SCHAKNE: Two Federal prosecutors with successful records in winning Medicaid fraud cases say more investigators are needed.

ROBERT FISKE, JR. [Federal Prosecutor, Southern District, New York]: The basic problem with the Medicaid program as we see it as law enforcement officers is that a system has been allowed to develop which is so loose and slipshod in its regulatory procedures that those operating within it have had virtually no fear of being caught. And in the unlikely event that they are caught, no fear of any significant penalty.

SCHAKNE: The hearings are now over. Whether any reform will follow is open to question. It's worth noting that in 1972, a New York grand jury, with a good deal of public fanfare, told virtually the same story of Medicaid fraud with some of the same villains, and nothing happened.

—Robert Schakne, CBS News, Washington.

MUDD: A Senate subcommittee attracted a lot of attention this week with public hearings on cheating by doctors and other abuses in Federally-supported health clinics, the so-called Medicaid mills. Today. Robert Schakne took a closer look at the charges.

ROBERT SCHAKNE: There are, by official estimate, 350 Medicaid mills within New York City - private health centers, operated for profit, catering to the very poor and depending on public funds for payment of their bills. They provide health care in ghetto neighborhoods where few private physicians are willing to practice, for fees set by law that average one-third what private doctors usually charge.

DR. MARTIN PARIS [Medical director, New York City Health Dept.]: We provide services to a population of New York City, and I would say in most urban centers throughout the United States who would have no other alternative. Studies tend to indicate when we look at the records very, very dispassionately for the overwhelming bulk of Medicaid mills that the care is mediocre. It's also mediocre in hospital outpatient departments, and it's frequently mediocre in most GP offices and private practitioners' offices.

SCHAKNE: Is 90 percent of the Medicaid mills' care substandard as Senate investigators say, or did two-thirds of the mills try to provide adequate care, as city officials say? One measure - Health Department officials say that poor people go to Medicaid mills in increasing numbers, even when hospital outpatient departments are also available. And a CBS News study of Senate records shows that in two-thirds of the Medicaid mills that Senate investigators checked while posing as patients, there was no clear evidence to indicate bad treatment. To put them in perspective, for all their visibility - good or bad - fraudulent or honest, Medicaid mills account for only a fraction, some seven percent of New York's annual Medicaid expenditures.



[SCHAKNE] That's not the way Senators sometimes portrayed it last week and this week when commenting on the amount of New York City Medicaid mill fraud.

QUESTIONER: How much?

SENATOR FRANK MOSS [Dem., Utah]: Well, a billion dollars a year.

QUESTIONER: In New York?

MOSS: In New York. Close to a billion, anyway.

SENATOR CHARLES PERCY [Republican, Illinois]: \$1-billion of New York total Medicaid funds are actually wasted or squandered.

SCHAKNE: The facts according to records no one has challenged: Medicaid mills don't take in anywhere near a billion dollars in New York - much less steal it or waste it. Medicaid mills collected \$130-million last year. The rest of the \$2-billion Medicaid budget went not to Medicaid mills but to hospitals and nursing homes. The fact is because the records are so bad and the regulations are so weak, nobody really knows the extent of the Medicaid mill problem. Senate investigators can't even say how much fraud they found in their own direct examination of the 55 Medicaid mills. They held their hearings before they'd located most of the invoices that the Medicaid mills submitted.

—Robert Schakne, CBS News, New York.



Mr. James Cannon
Chairman, Domestic Council
The White House
Washington, D.C. 20500

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NEWS**

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file

THE WHITE HOUSE

WASHINGTON


September 9, 1976

MEETING WITH NATIONAL POSTER CHILD FOR SICKLE CELL ANEMIA

Friday, September 10, 1976

12:15 p.m. (5 minutes)

The Oval Office

From: Jim Cannon 

I. PURPOSE

To meet nine year old Bridgett Earby of San Francisco, the 1976 national poster child for sickle cell anemia.

II. BACKGROUND, PARTICIPANTS & PRESS PLAN

A. Background: The National Association for Sickle Cell Disease, Inc. (NASCD), founded in 1971, has sought to provide leadership in the effort to heighten public awareness of the particular impact of sickle cell anemia and the sickle cell trait on the health, economic, social and educational development of the black individuals they uniquely affect and their families. Recently, with federal support, the Association conducted several educational workshops throughout the country which attracted many professional and lay participants involved in sickle cell research and service.

The Board of Directors of NASCD has designated September as National Sickle Cell Month, and, for the first time, has appointed a National poster child.

B. Participants: See attached list

C. Press Plan: White House Photographer

III. TALKING POINTS

1. I am delighted, Bridgett, to have you here at the White House for a visit. You are honored to be the first national poster child for sickle cell anemia.
2. I salute the Foundation and its staff for the wonderful work they have done in the field of sickle cell anemia.



PARTICIPANTS

Bridgett Earby, National Poster Child for Sickle Cell Anemia

Mrs. Geraldine Earby, Poster Child's Mother

Dr. Charles Whitten, President, National Association for Sickle Cell Disease, Inc.

Ms. Dorothye Boswell, Executive Director, National Association for Sickle Cell Disease, Inc.

Dr. Clarice Reid, Chief, Sickle Cell Disease Branch, National Institutes of Health



THE WHITE HOUSE
WASHINGTON

September 9, 1976

MEMORANDUM TO:

JIM CANNON

FROM:

SPENCER JOHNSON

SUBJECT:

National Health Fair Week

I have reviewed the attached telegram from Mr. Maury Wills of Los Angeles, suggesting that the President declare the week of September 19 as National Health Fair Week.

Although in a generic sense the proposal has merit I must recommend against such action because:

1. Because of the short notice involved, the National participation by all groups who would be interested in such a preventive health effort could not be maximized; and
2. Such action at this point would benefit only one community and only one organization.

Some individual message of encouragement or support from Dr. Cooper, the Assistant Secretary for Health, or the President, would be in order.

I would be glad to follow through with this if you think it is appropriate.



[Handwritten signature]

1976

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PMS PRESIDENT FORD

WHITE HOUSE DC 20500

DEAR PRESIDENT FORD: I JOIN WITH THE ORDER OF THE HOLY FELLOWSHIP IN
REQUESTING YOU TO DECLARE THE WEEK OF SEPTEMBER 19TH AS NATIONAL
HEALTH FAIR WEEK

THE ORDER, AS WELL AS CULVER CITY CALIFORNIA, AND THE SURROUNDING
AREA, ARE SPONSORING A HEALTH FAIR WHERE FREE MEDICAL, DENTAL, AND
COUNSELING SERVICES WILL BE PROVIDED, AS WELL AS FREE GIFTS, DONATED
BY CONCERNED BUSINESSMEN.

AS YOU KNOW, I HAVE ALWAYS BEEN INVOLVED IN PHYSICAL FITNESS AND
HEALTH, AND WHOLEHEARTEDLY SUPPORT THIS UNIQUE PREVENTIVE CONCEPT OF
INCREASING HEALTH AWARENESS ON A COMMUNITY LEVEL.

IN MY OPINION THIS IDEA OF COMMUNITY SELF RELIANCE IS DESERVING OF

THE WIDEST POSSIBLE ENCOURAGEMENT AND SUPPORT. THE DIGNITY OF YOUR
OFFICE WOULD LEAD TO THE ACTUALIZATION OF THIS CONCEPT. SINCERELY

MAURY WILLS

LA DODGERS

NBC SPORTS NETWORK

NNNN



THE WHITE HOUSE
WASHINGTON

September 9, 1976

MEMORANDUM FOR: PHIL BUCHEN
ROBERT T. HARTMANN
JACK MARSH
MAX FRIEDERSDORF
JIM LYNN
GUY STEVER

FROM: JIM CANNON *At Ques*

SUBJECT: PRESIDENTIAL LETTERS TO SENATORS KENNEDY
AND JAVITS



Attached for your comments and recommendations are two drafts for the President's signature.

The first is a memorandum to all Department and Agency heads concerning their participation in an interagency committee formed to coordinate federal action in recombinant DNA experiments. Scientists had declared a self-imposed moratorium on such experiments for two years while they awaited guidelines from NIH. These guidelines were issued in June. The President's memo is to assure the cooperation and participation of each Department and Agency conducting or supporting recombinant DNA experiments with the interagency committee and the guidelines.

The second is a draft response to Senators Kennedy and Javits. Their letter to the President is also attached. They are concerned that the NIH guidelines are not sufficient and suggest further action. Senator Kennedy has also scheduled hearings on recombinant DNA experimentation for October 22.

Because we would like to present these to the President for his action as soon as possible, I would appreciate having your comments and recommendations sent to Sarah Massengale, Room 220, Ext. 6776 by 3:00 p.m., Thursday, September 9.

Thank you.

THE WHITE HOUSE
WASHINGTON



DRAFT

MEMORANDUM FOR FOR THE HEADS OF DEPARTMENTS AND AGENCIES

On June 23 the Department of Health Education and Welfare released guidelines for the conduct of research involving the creation of new forms of life used in studying genetics (recombinant DNA experiments). These guidelines establish carefully controlled conditions for experiments in which foreign genes are inserted into microorganisms, such as bacteria. The object of the guidelines is the containment of these possibly dangerous organisms while permitting research of great potential benefit to mankind.

The guidelines extend a moratorium that the scientists themselves imposed on certain experiments involving recombinant DNA. Recombinant DNA research has strong potential in medicine as well as in science and technology generally. There are risks, however. The NIH guidelines prohibit certain types of experiments; other experiments will go forward under special safety conditions. The provisions will afford protection with a wide margin of safety to workers and the environment while permitting research to proceed.

HEW expects these guidelines to be supported by the largest part of the scientific community and will use them to govern research at laboratories of the National Institutes

of Health and at those of its grantees and contractors. Of special concern to the public is the extension of these guidelines beyond the purview of NIH.

In light of the great public concern, Secretary Mathews will be convening an interagency committee. The purpose of the committee will be to review Federal policies on the conduct of research involving recombinant DNA.

Since there are no precedents for an endeavor of this sort, I am issuing this directive to assure the participation of each department and agency conducting or supporting recombinant DNA experiments. Secretary Mathews will take the lead in this, but it is essential that all Federal Department and Agency Heads give him their full cooperation.

Thank you.

Gerald R. Ford



The Honorable Edward M. Kennedy
Chairman, Subcommittee on Health
Committee on Labor and Public Welfare
United States Senate
Washington, D. C. 20510

DRAFT

Dear Mr. Chairman:

I am writing in response to your and Senator Javits' letter of July 19 concerning the National Institutes of Health (NIH) Guidelines on Recombinant Deoxyribonucleic Acid (DNA) Research. As you note in your letter, the Guidelines were developed over an 18-month period and involved the participation not only of the scientific community but of the public as well.

The potential scientific and medical benefits in this research area are promising. Support for the research is merited with appropriate safeguards against possible hazards. The decision of the Director, NIH, that accompanied the release of the Guidelines explained in great detail the care and consideration given stated public concerns for safety.

The application of these Guidelines beyond the NIH to the public and private sectors indeed merits further consideration. In order to provide this review, Secretary Mathews has proposed that an interagency committee be created to review the activities of all Government agencies conducting or supporting recombinant DNA research or having regulatory authority relevant to this scientific field. The committee could also coordinate activities with non-Federal institutions. I have written to all Department Secretaries urging their cooperation and participation in naming representatives to serve on this proposed committee.

Page 2 - The Honorable Edward M. Kennedy

The committee will perform a number of duties. It will answer questions; facilitate compliance with the Guidelines in the public and possibly private sectors; and provide coordination among several Government agencies that support and conduct this research. Further, the committee will report to Secretary Mathews and my office on appropriate executive or legislative actions that might be required as a result of their policy review. By this means I believe the concerns you address in your letter will receive careful attention. You will be apprised of the deliberations of this committee and any recommendations that may be forthcoming.

I want to thank you very much for your thoughtful letter.

Sincerely yours,

Same reply to Senator Javits

Perpich, NIH/OD, 496-3152



13
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United States Senate

COMMITTEE ON
LABOR AND PUBLIC WELFARE
WASHINGTON, D.C. 20510

July 19, 1976

The President
The White House
Washington, D.C.



MF
Dear Mr. President:

For several years, the biomedical research community has been engaged in an extremely important debate over the safety of certain types of genetic research. The research involves combining genetic material from different organisms. The technology that permits this type of genetic experimentation, called recombinant DNA research, is revolutionary, and holds the promise of enormous benefits in our understanding of disease processes, and could lead us to ways of controlling or treating complex diseases such as cancer and hereditary defects. It could conceivably lead to improved ways of producing such important hormones as insulin, clotting factors, and enzymes important to treatment of many diseases. The technology also has conceivable applications in agriculture and industry. Clearly, it is a research area of enormous promise.

However, recombinant DNA research also entails unknown but potentially enormous risks due to the possibility that micro-organisms with transplanted genes might prove hazardous to human and other forms of life--and might escape from the laboratory. Indeed, scientists engaged in such research declared a voluntary moratorium on recombinant DNA research in 1974 when they foresaw the possibility, for example, of creating in the laboratory self-propagating infectious bacteria that contain genes from cancer-causing viruses. The moratorium was lifted in 1975, but maintained, again by the researchers themselves, for the specific types of experiment which might produce cancer-causing bacteria, raise the resistance of antibiotics of known bacteria, or have other dangerous results.

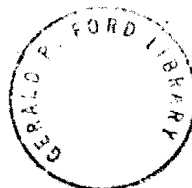
On June 23rd of this year, the National Institutes of Health issued comprehensive guidelines for recombinant DNA research which specify more stringent safety and containment measures than are currently required or practiced in many areas. They specifically prohibit the most potentially dangerous types of experiments. In addition, the guidelines prohibit the release into the air or water or environment of any of the genetic materials created by the research.

We appreciate the great care NIH has taken, in the formulation of these strict guidelines, in obtaining the best scientific advice as well as advice from experts in law and ethics. Opportunity was also given for the public to comment on the guidelines. The environmental impact assessment of the guidelines currently being prepared by NIH will offer further opportunities for such comment.

The guidelines will be widely discussed and debated with regard to their ultimate adequacy in safeguarding the public, and they will no doubt further evolve and develop during this debate and as our understanding of recombinant DNA advances. Based on the process by which NIH produced the present guidelines, we are confident they are a responsible and major step forward and reflect a sense of social responsibility on the part of the research community and the NIH.

However, we are gravely concerned that these relatively stringent guidelines may not be implemented in all sectors of the domestic and international research communities and that the public will therefore be subjected to undue risks. The National Institutes of Health has the authority to require adherence to the guidelines as a condition of their grants and contracts for research, but they cannot enforce the guidelines with respect to other Federal agencies, with respect to research in the private sector in this country, and with respect to research done in other nations.

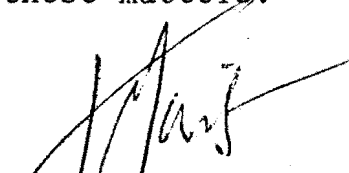
In particular, it is clear that recombinant DNA research has great potential in the private sector, such as pharmaceutical manufacture, the oil industry and agricultural products. It is also clear that some elements of the guidelines, such as limitations on the size of experiments, public disclosure, and non-release of materials into the environment, may be contrary to the interest and practice of research in private industry, and may therefore be ignored. In addition, since private sector research will lead to industrial application, guidelines must be extended beyond research into application and production stages. If the NIH guidelines are necessary to protect the public in Federally funded research, it is clear they are necessary for privately funded research and application as well.



The President
Page Three

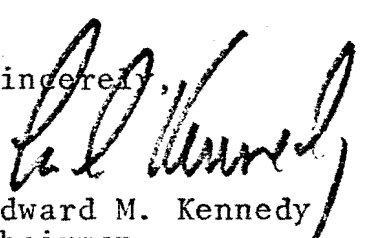
Given the high potential risks of this research, it seems imperative that every possible measure be explored for assuring that the NIH guidelines are adhered to in all sectors of the research community. We urge you to implement these guidelines immediately wherever possible by executive directive and/or rulemaking, and to explore every possible mechanism to assure compliance with the guidelines in all sectors of the research community, including the private sector and the international community. If legislation is required to these ends, we urge you to expedite proposals to Congress.

This is an unprecedented issue in the area of biomedical research. It has been likened in importance to the discovery of nuclear fission. In the interest of public safety, and in the interest of permitting this beneficial research to continue with the blessing of a reassured public, we must act expeditiously on these matters.



Jacob K. Javits
Ranking Minority Member
Committee on Labor and
Public Welfare

Sincerely,



Edward M. Kennedy
Chairman
Subcommittee on Health



cc: Quern

September 11, 1976

MEMO FOR: JIM CANNON

FROM: JIM CAVANAUGH ^{JHC}_W

Jim, you and Art might be interested in the attached.

AA
Any suggestions?
Jw



Jim --

9/7

The enclosed material was sent to me at the request of Matt Patton, an Atlanta trial lawyer with whom I've had some contact on other matters.

The reason it was sent was that Carter's "policy planning" group in Atlanta has held two meetings -- one on August 9, and one on August 26 -- on health affairs. The August 9 meeting was put together to sort of introduce the players, and after the meeting Carter's people sent out a very detailed list of questions to be answered ^{before} the August 26 meeting. The answers were then discussed at the August 26 meeting.

The fellow who sent me the material sent it because he doesn't think that this sort of thing should be done on a partisan basis, and he forced the members of his chapter to allow him to send it here. He believes that the product of the August 26 meeting will be worked into a Carter health policy speech in the not so distant future.

According to Dr. Bennett, who was represented at the meetings, the participants were:



Carter Staff: Jack Watson, Jules Sugarman, Joe Levitt

Outside: Drs. Merritt Low and Robert Frazier, American Academy of Pediatrics (one of them is a past president)

Drs. Roy Parker and Erwin Nichols, American College of Obstetrics and Gynecology (one of them is a past President)
Gabriel Stickle and Charlotte Wilen, National Foundation for the March of Dimes

Drs. Kretschmer, Sidburn and Gil Hill (?), National Institute of Child and Human Development.

I have indicated to Bennett that I would refer his material to a member of the Senior staff, and that he would be contacted if this seemed appropriate. I am referring it to you at Foster's suggestion.

George VanCleave

Georgia Chapter
American Academy of Pediatrics
1467 Harper Street
Augusta, Georgia 30902
404/724-7533

August 28, 1976

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Youth
W. SCOTT JAMES, M.D.

Dear Mr. Van Cleve,

Matt Patton told me that
he has given you some background
information on the enclosed paper.

I do hope that these thoughts
will get to President Ford for his consideration.
This paper was presented to representatives of
Carter in Atlanta, August 9, 1976.

Will be happy to discuss this with
you.

Sincerely yours,
James W. Bennett, 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

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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.

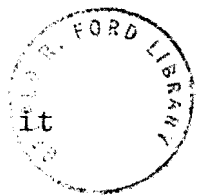
E. Research

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.

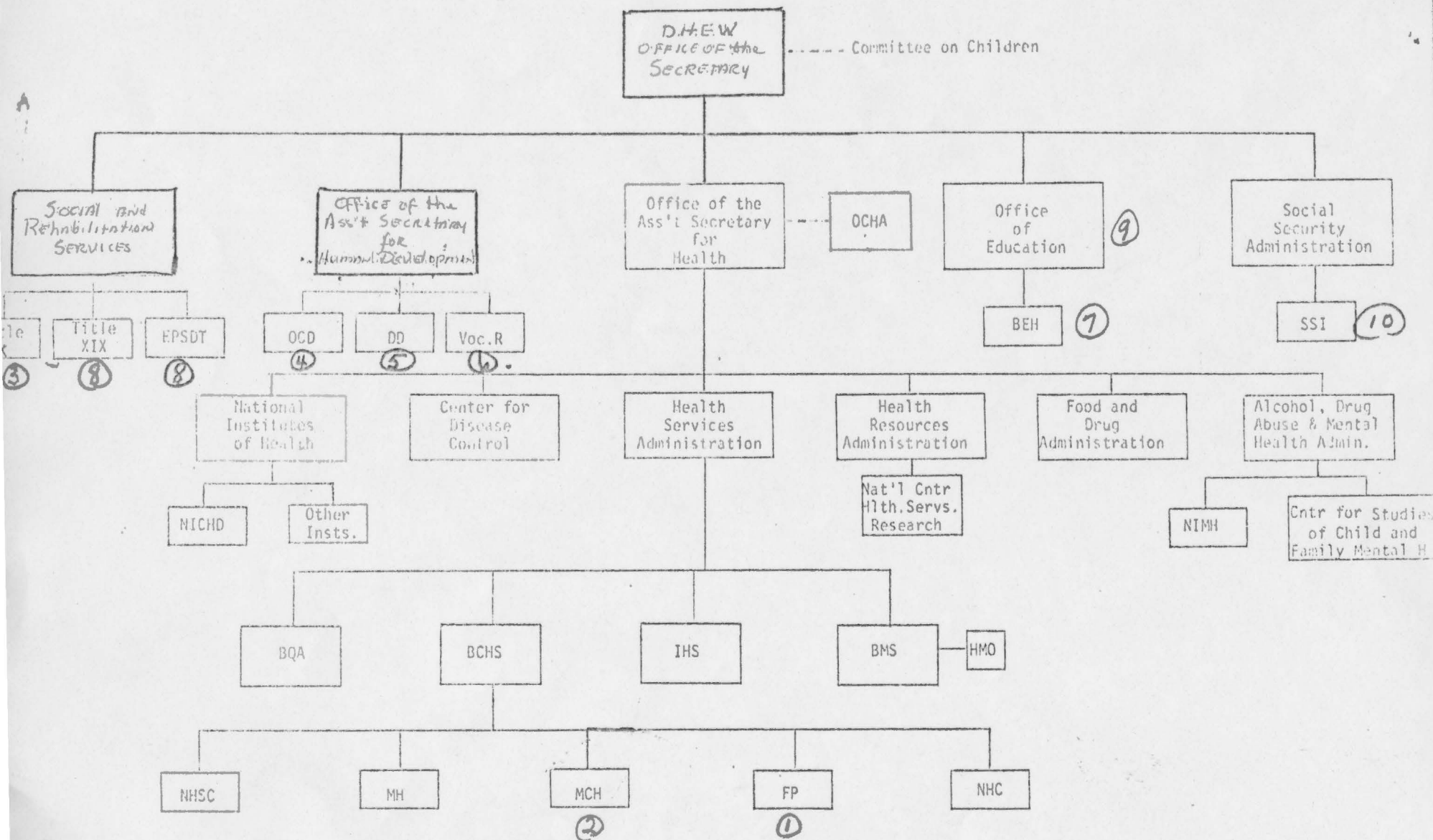
The Council is aware of and plans to study S 3593 and has reviewed in depth, H 12937 shortly after its initial publication.

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

cc: Quern

Pending

September 11, 1976

MEMO FOR: JIM CANNON

FROM: JIM CAVANAUGH *JHC*

Jim, you and Art might be interested in the attached.



AA
Any suggestions?
Jim

9/7

Health

The enclosed material was sent to me at the request of Matt Patton, an Atlanta trial lawyer with whom I've had some contact on other matters.

The reason it was sent was that Carter's "policy planning" group in Atlanta has held two meetings -- one on August 9, and one on August 26 -- on health affairs. The August 9 meeting was put together to sort of introduce the players, and after the meeting Carter's people sent out a very detailed list of questions to be answered at the August 26 meeting. The answers were then discussed at the August 26 meeting.

The fellow who sent me the material sent it because he doesn't think that this sort of thing should be done on a partisan basis, and he forced the members of his chapter to allow him to send it here. He believes that the product of the August 26 meeting will be worked into a Carter health policy speech in the not so distant future.



According to Dr. Bennett, who was represented at the meetings, the participants were:

Carter Staff: Jack Watson, Jules Sugarman, Joe Levitt

Outside: Drs. Merritt Low and Robert Frazier, American Academy of Pediatrics (one of them is a past president)
Drs. Roy Parker and Erwin Nichols, American College of Obstetrics and Gynecology (one of them is a past President)
Gabriel Stickle and Charlotte Wilen, National Foundation for the March of Dimes
Drs. Kretschmer, Sidburn and Gil Hill (?), National Institute of Child and Human Development.

I have indicated to Bennett that I would refer his material to a member of the Senior staff, and that he would be contacted if this seemed appropriate. I am referring it to you at Foster's suggestion.

George

George VanCleave

Health

THE WHITE HOUSE
WASHINGTON

September 13, 1976

Mike — file
we showed
we O'Neill's

MEMORANDUM FOR:

JIM CANNON
MIKE DUVAL

FROM:

PHILIP BUCHEN

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SUBJECT:

New Estimate of The Cost
of The Health Security
Proposal (Kennedy-Corman)

supported

Gordon Trapnell, an independent consulting actuary, has presented to HEW a study he has recently made of the probable cost of the health security proposal which was introduced in the 94th Congress by Senator Kennedy and Representative Corman. He advises me that HEW will probably release the results of his study within a week, and I think it is important that we encourage HEW to give wide publicity to this matter. I believe William Morrill, Assistant Secretary of HEW for Planning and Evaluation, is in charge of releasing the report.

by Rand Corp

analysis

Also, you may want to make immediate use of Trapnell's findings to explain why this Administration opposes the proposal and the extent to which it would pose a horrendous burden on the Federal Government and the taxpayer.

Analysis

A short summary of Trapnell's findings is attached. On the last page is an explanation of his qualifications for making this study.

Jim

Attachments

Trapnell's figures are
Not Solid, says O'Neill.

THE COST OF THE HEALTH SECURITY PROPOSAL



The Health Security proposal would cost the American taxpayers approximately \$181 billion by fiscal 1980. Of this, some \$141 billion would be new Federal spending, and new taxes of this amount would be required to pay for the program. Total Federal spending for personal health services would more than triple from \$60 billion under present law to \$192 billion under the proposal.

Much of this spending results from discontinuing state or private programs, or from paying for bills now borne directly by the consumer. A considerable portion, however, is new spending. Total spending for health care in the United States would be about \$28 billion more than under present law, an increase of roughly 12%.

The new Health Security program would have a much larger budget than any other branch of government, including the Defense Department. The program would spend half again more than the Social Security programs, and require tax increases larger than current Social Security taxes. Payroll taxes for Social Security and Health Security would rise to 17% compared to the 10.85% under the present law. This increase would fund only one half the program. Additional funds equivalent to 7% of payrolls would have to be raised by other forms of taxation.

These enormous expenditure figures only begin to describe the nature of the huge changes that would take place in the medical care received by Americans. Payment for a large proportion of the services used by most persons would come solely from the Health Security Program. (A Health Security Board would be established to regulate and control every aspect of health care in the United States.) Payment for services to any physician or hospital or other health provider would depend on the approval of this Board.

Not only would the total cost of the program be enormously high, it would probably increase rapidly. Each class of medical personnel would be encouraged to organize and bargain collectively with the Federal government. Strikes by physicians, nurses, physical therapists, home health aides, etc. may become a frequent occurrence, with medical facilities and services closing down as other practitioners honor their picket lines.

Restrictions on the use of services are likely also to become commonplace as the cost of the program increases. Providers could find themselves devoting as much effort to fighting red tape as in curing diseases. The public would suffer both as patients and as taxpayers. Again, additional bureaucracies would be established in the attempt to solve problems created by the very existence of the program.

The high cost of health care and the rapid rate at which it is increasing are severe chronic problems for the American economy and the average taxpayer. While these problems must be dealt with, the Health Security program would be a cure that is far worse than the disease.

EFFECT OF HEALTH SECURITY PROPOSAL ON SPENDING FOR PERSONAL HEALTH SERVICES IN FISCAL 1980

(Billions of Dollars^{1/})

	<u>Present Law</u>	<u>Health Security</u>	<u>Net Changes</u>
TOTAL U.S.	226.3	251.4	+25.1 ^{2/}
PRIVATE SECTOR	140.8	48.0	-92.8
Out of pocket	71.0	38.7	-32.3
Private insurance	63.7	4.3	-59.4
Workmen's compensation	3.5	3.4	-.1
Other private	2.6	1.6	-1.0
PUBLIC SECTOR	85.5	203.4	+117.9
Government insurance	3.8	1.1	-2.7
Federal taxpayers	60.0	191.7	+131.7
Health Security ^{2/}	0	172.6 ^{3/}	+172.6 ^{3/}
Medicare	29.8	0	-29.8
Medicaid	13.8	6.3	-7.5
Other programs	16.4	12.8	-3.6
State and local taxpayers	21.7	10.6	-11.1

1/ Assumes an increase in CPI of 5.5% per year from Fiscal 1976 to Fiscal 1980.

2/ Excludes \$3.1 billion in new spending for development of health resources resulting from the Health Security proposal.

3/ Excludes \$8.8 billion in spending for development of health resources (of which \$3.1 billion is new spending).



NEW SPENDING FOR HEALTH SERVICES
UNDER THE HEALTH SECURITY PROPOSAL IN FISCAL 1980

Additional services performed	\$20.7 billion
New services created	.5
Payment of bad debts and unbilled charges	6.0
Full payment for Medicaid services	1.9
Full payment for Medicare services	1.3
Increase in wages of institutional health employees (beyond that financed by windfall increases in revenue)	1.4
Utilization controls	-1.8
Limits on increases in institutional spending	-3.4
Recovery of windfall increases in institutional spending (from recovery of bad debts, etc.)	-1.4
Limits on charges by professional providers	-4.5
Administration of new insurance	7.5
Reduced administrative functions	-2.9
Increase in planning, regulation, and evaluation	.2
Reduction in individual insurance expenses	-2.4
Maintain Federal facilities	.9
Diversion of philanthropic donations to other purposes	1.1
New Federal spending for health resources development	<u>3.1</u>
TOTAL	\$28.2 billion

EFFECT OF HEALTH SECURITY PROPOSAL ON SPENDING FOR PERSONAL HEALTH SERVICES IN FISCAL 1980
(Billions of 1976 Dollars)

	<u>Present Law</u>	<u>Health Security</u>	<u>Net Changes</u>
TOTAL U.S.	180.2	200.2	20.0
PRIVATE SECTOR	112.1	38.2	-73.9
Out of pocket	56.5	30.8	-25.7
Private insurance	50.7	3.4	-47.3
Workmen's compensation	2.8	2.7	-.1
Other private	2.1	1.3	-.8
PUBLIC SECTOR	68.1	162.0	+93.9
Government insurance	3.0	.9	-2.1
Federal taxpayers	47.8	152.7	+104.9
Health Security <u>1/</u>	0	137.5	+137.5
Medicare	23.7	0	-23.7
Medicaid	11.0	5.0	-6.0
Other programs	13.1	10.2	-2.9
State and local taxpayers	17.3	8.4	-8.9

1/ Excludes \$7.0 billion in spending for development of health resources (not included in personal health services).

Source: "A Comparison of the Costs of Major National Health Insurance Proposals," by Gordon R. Trapnell, F.S.A. Prepared under Contract No. HEW-OS-74-138.

NEW SPENDING FOR HEALTH SERVICES

UNDER THE HEALTH SECURITY PROPOSAL IN FISCAL 1980
(Billions of Fiscal 1976 Dollars)

Additional services performed	\$16.5 billion
New services created	.4
Payment of bad debts and unbilled charges	4.8
Full payment for Medicaid services	1.5
Full payment for Medicare services	1.0
Increase in wages of institutional health employees (beyond that financed by windfall increases in revenue)	1.1
Utilization controls	-1.4
Limits on increases in institutional spending	-2.7
Recovery of windfall increases in institutional spending (from collection of bad debts, etc.)	-1.1
Limits on charges by professional providers	-3.6
Administration of new insurance	5.9
Reduced administrative functions	-2.3
Increase in planning, regulation, and evaluation	.2
Reduction in individual insurance expenses	-1.9
Maintain Federal facilities	.7
Diversion of philanthropic donations to other purposes	.9
New Federal spending for health resources development	<u>2.5</u>
TOTAL	\$22.5 billion

These estimates are available as a result of new research conducted into the cost of national health insurance programs by Gordon R. Trapnell, an authority in estimating costs of major new health insurance programs. Mr. Trapnell has enjoyed a highly successful record in preparing estimates for major national health insurance programs, and consequently his studies carry an unusual degree of credibility. For example, he prepared the estimates that led to setting the initial rate for Part B of Medicare at \$3, a rate that proved to be within a few percent of the actual cost of the program. Similarly, his estimates of the cost of extending the Medicare program to include disabled beneficiaries and persons suffering from chronic kidney disease have proved to be accurate guides for financing those programs. Another example of Mr. Trapnell's reliability in forecasting health insurance costs was provided by his estimates as to the effect of removing economic control from health services in 1974, when he estimated within a few percent the rates of increase that would occur in the major types of health services, and the overall level of spending that would occur. Estimating the cost of national health insurance programs is a considerably more difficult task; but no other authority has established such a consistent record of reliable estimates in this field.

