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ABSTRACT

Proceedings from the second session of hearings on the Maternal and Child Health Care Act are presented in this document. A copy of the bill (H. R. 1702) which proposes the provision of comprehensive health care services for pregnant women and children from birth to age 18 is included. Also included are testimony and statements of expert witnesses, statements prepared by professional organizations, previously published articles dealing with relevant issues, and letters submitted for the record. (JMB)

MATERNAL AND CHILD HEALTH CARE ACT—1977

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

OF THE

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE

HOUSE OF REPRESENTATIVES

NINETY-FIFTH CONGRESS

SECOND SESSION

ON

H.R. 1702

A BILL TO ESTABLISH A NATIONAL SYSTEM OF MATERNAL AND CHILD HEALTH CARE

JANUARY 4 AND 5, 1978

Serial No. 95–86

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MATERNAL AND CHILD HEALTH CARE ACT—1977

WEDNESDAY, JANUARY 4, 1978

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT,
INTERSTATE AND FOREIGN COMMERCE COMMITTEE,
San Francisco, Calif.

The subcommittee met, pursuant to notice, at 9:30 a.m., room 13154 in the Federal Building, Hon. James H. Scheuer, presiding [Hon. Paul G. Rogers, chairman].

Mr. SCHEUER. The hearing of the subcommittee on Health and the Environment of the Interstate and Foreign Commerce Committee is hereby called to order.

We should have an extremely interesting and provocative day. We have a number of very excellent witnesses today and tomorrow.

I do want to start out by thanking Dr. Peter Budetti and Dr. Phil Lee of the University of California. Dr. Budetti has earned our particular thanks and gratitude for the long hours of concentrated work and effort that he has put in in helping us piece together this hearing. I especially want to thank Phil Lee for working with Dr. Budetti and guiding the development of this hearing.

Dr. Lee, a former Assistant Secretary of the Department of Health, Education, and Welfare, is a long and valued friend of mine. I consider him one of the very bright lights in the health care field today in our country. He is truly a national asset and a great national resource. I want to thank Dr. Phil Lee and Dr. Peter Budetti for their absolutely marvelous efforts above and beyond the call of duty in assisting us in putting together these hearings.

We are considering today a bill to establish a national maternal and child health care program in our country. Although children under 18 are approximately one-third of our population, less than 10 percent of our health care dollars go to children. They are vastly underserved at the Federal, State, and local level.

The EPSDP program for the early and periodic screening, diagnosis and treatment of young people has been extremely disappointing—a disaster really. We failed to meet even the minimum goals of the Federal programs that have existed.

The figures for our negligence and our unconcern are heartbreaking and shameful for a country as rich as ours. We rank fifteenth in the world in infant mortality. I think every American has to feel a sense of shame about that. I think we should feel a sense of shame that the infant mortality rate for minority children is two-thirds again as high as it is for white children. Somewhere along the line we have lost the promise of the Constitution and the Statue of Liberty.

Ten million U.S. children out of 67 million receive no health care at all. About half of all of our children under the age of 15 have never seen a dentist. Nineteen million of our children are not fully immunized against polio; 14 million are unprotected against measles and rubella, 13 million are not immunized against diptheria, whooping cough and tetanus, and 25 million are not immunized against mumps.

About one-third of all of our women get no significant prenatal care, obstetrical care or inadequate health care.

So we are talking about a system that has to be changed. We are spending about $160 billion a year, and yet our health care is inadequate. Costs are rising astronomically. Six months ago I was saying $140 billion and 3 months ago I was saying $150 billion; now estimate are $160 billion. I checked with Karen Nelson, staff member of the Interstate and Foreign Commerce Committee, and she tells me that HEW is now estimating expenditures of $180 billion in fiscal year 1978. We will soon be spending $180 billion for health care in the country, over 9 percent of our GNP, a substantially higher percentage GNP than any other country in the world. Yet we are getting far less than the best, to quote a phrase, in terms of health outputs.

It seems to me that all the CAT scanners and all the open heart surgery units in the world are not going to materially affect our health outputs. The only thing that is going to affect our health outputs will be the day when we can get Americans to become more concerned about health outputs in terms of their own personal behavior, in terms of their own ingestion of alcohol, tobacco, drugs, in terms of their control over their diets, their exercise, their nutritional intake, their proclivity to involve themselves in violence, violent accidents and violent activities.

Prof. Victor Fuchs has written a remarkably interesting book that formed part of my early education in health care delivery systems, called Who Shall Live. In that book he has a table in which he describes the enormous incidents of violent accidents and violent acts as a major cause of morbidity among young people. It is the single largest cause of death for black males from 18 to 25. Violence.

A major part of the job that we have to do to improve our health output in this country is teaching our young people to take responsibility and show concern for their own health.

The bill we are considering today provides a whole refocus and a restructuring of our health service delivery program. It moves the emphasis away from delivery of health services in a sickness care setting in hospital beds, from CAT scanners and open heart surgery, from a system adorned by a number of highly paid and highly skilled specialists. The emphasis moves toward a preventative health care model where a lot of the services are delivered in neighborhoods on an outpatient basis and on an ambulatory basis by paraprofessionals. A significant percentage of the services are preventive and educational, and are directed at enabling young people to take care of their own health outputs.

During the hearing today, we are going to hear from Dr. Chuck Lewis of Los Angeles. He has done some remarkable work in working with young people to educate them to the need for showing concern and responsibility for their own health.

These are the goals of the bill. We have had hearings similar to this in both Washington [1] and New York.[2] This is our third set of hearings. We have made significant changes in the bill as a result of the testimony that we took and the counsel that we received in Washington and New York. I have no doubt whatsoever that as a result of the testimony today and the questions and answers that will be provoked as part of our learning process that further changes and further fine tuning of the legislation will result.

With those few words, I want to thank you all for coming.

Without objection I will place my prepared statement at this point in the record.

[Mr. Scheuer's opening statement follows:]

STATEMENT OF HON. JAMES H. SCHEUER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

On behalf of the Health and Environment Subcommittee of Interstate and Foreign Commerce, it is a great pleasure for me to open two days of hearings on the Maternal and Child Health Act, a proposal which provides comprehensive health care services to pregnant women and children from birth to age 18. There are presently over 67 million children who would be eligible for these benefits, as well as 40 million women in the childbearing age group. Children and youth comprise one-third of our population, yet little more than ten cents out of every health dollar spent in the United States presently goes towards child health.

Since the introduction of the Maternal and Child Health Act in June 1976, this proposal has received widespread support not only in Congress but also among academic leaders in the field of maternal and child health and leading interest groups representing this target population. The Maternal and Child Health Care Act is co-sponsored by over 25 House members. On the Senate side, it was introduced by Senator Jacob Javits and sponsored by Senators Cranston, Brooke and Humphrey.

With Medicare and Medicaid, the federal government pledged its commitment to providing improved health care coverage for our poor and elderly. Now it is time to focus on our nation's youth, our most valuable natural resource. Although we are spending more than 160 billion dollars a year on health care in this country and can be proud of our advanced medical technology as well as our impressive record in bio-medical research, there is a great deal of improvement needed in the delivery of maternal and child health care:

The U.S. ranks fifteenth in the world rate of infant deaths; even worse, the mortality rate of minority infants is two thirds again as high as the rate for white infants.

Perhaps ten million U.S. children under age 16 receive no medical care in the United States.

About half of all children in the United States under the age of 15 have never seen a dentist.

Thirty percent of pregnant women in the United States, the world's most developed nation, receive inadequate obstetrical care.

19 million children are not fully immunized against polio; 14 million youngsters are unprotected against measles and rubella; 13 million are not immunized against diptheria, whopping cough and tetanus; and 25 million are not immunized against mumps.

The United States currently lacks a centralized, effective and well coordinated child and maternal health care program. There are some 56 programs in 5 departments, 15 agencies and 45 bureaus dealing with children. Organization is fragmented and many important needs are not being met.

The Maternal and Child Health Care Act not only provides a comprehensive benefit package for both mothers and children but even more important, it creates incentives for changing the setting and manner in which services are delivered

[1] See "Maternal and Child Health Care Act," hearing before the Subcommittee on Health and the Environment, Committee on Interstate and Foreign Commerce, 94th Congress, held on June 16, 1976, Serial No. 94–98.

[2] See "Maternal and Child Health Care Act—1976," supplemental hearing before the Subcommittee on Health and the Environment, Committee on Interstate and Foreign Commerce, 94th Congress, held on September 13, 1976, Serial No. 94–117.

in order to make needed health programs accessible, appropriate and more cost effective without sacrificing quality. Our goal must be to design an effective "health care" rather than "sickness care" system, with emphasis on ambulatory rather than tertiary care, on preventive health measures which can significantly reduce the incidence of acute health problems, and on the best use of health care providers, paraprofessionals and health educators.

We have had previous hearings on the Maternal and Child Health Care Act. As a result of these hearings and hundreds of letters from experts in the field we have revised the legislations in order to strengthen and improve it. I am eager to hear from our panel of distinguished witnesses on our proposed changes to the Maternal and Child Health bill. Before we begin, however, I would like to express my deepest appreciation to the University of California's Health Policy Program for their extensive enthusiastic help in organizing and staffing these two days of hearings. Dr. Peter Budetti deserves a special thanks for his hard work and helpfulness. Dr. Phil Lee, Director of the Program has long been a friend of mine and I consider him one of the great bright lights in the health policy field. Thanks again for your efforts and success in gathering such an impressive group of experts to testify on the legislation before us today.

Mr. SCHEUER. Without objection, the text of H.R. 1702 will be printed at this point in the record.

[Testimony resumes on p. 79.]

[The text of H.R. 1702 follows:]

95TH CONGRESS
1ST SESSION

H. R. 1702

IN THE HOUSE OF REPRESENTATIVES

JANUARY 11, 1977

Mr. SCHEUER (for himself, Mr. CONYERS, Mr. CHARLES H. WILSON of California, Mr. BINGHAM, Ms. CHISHOLM, Mr. DE LUGO, Mr. OTTINGER, Mr. ROSENTHAL, Mr. DRINAN, Mr. DIGGS, Mr. ZEFERETTI, Mr. FRASER, Mr. MITCHELL of Maryland, Ms. BURKE of California, Ms. HOLTZMAN, Mr. MILLER of California, Mr. MAGUIRE, Mr. PEPPER, Mr. RANGEL, Mr. ROYBAL, Mr. STOKES, Mr. HAWKINS, and Mr. RICHMOND) introduced the following bill; which was referred jointly to the Committees on Interstate and Foreign Commerce and Ways and Means

A BILL

To establish a national system of maternal and child health care.

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

SHORT TITLE

SECTION 1. This Act with the table of contents may be cited as the "Maternal and Child Health Care Act".

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FINDINGS AND DECLARATION OF PURPOSE

SEC. 2. (a) The Congress finds and declares that—

(1) the mothers and children of this Nation are the foundation of its future strength, productivity, and prosperity;

(2) adequate health care for mothers and children is essential to safeguard this precious resource; and

(3) adequate medical care for pregnant women and children has the greatest potential for improving the health status of the general population.

(b) The purpose of this Act is—

(1) to establish a system of national health care benefits for children and pregnant women residing in the United States;

(2) to increase the access of such individuals to health care, to enhance its quality, and to emphasize the prevention of disease as well as the treatment of illness; and

(3) to improve the efficiency and the use of resources and to restrain the increasing costs of maternal and child health care, while providing fair and reasonable compensation to those who furnish it.

FREE CHOICE BY PATIENT AND PRACTITIONER

SEC. 3. The administration of this Act shall not interfere with the freedom of any physician or any patient to choose where and how they will give or receive health care. Neither the Secretary, the Board, nor any of their agents, shall make medical decisions with respect to a patient's health care; this function is reserved solely to the physician and his peers.

OBSERVANCE OF RELIGIOUS BELIEFS

SEC. 4. Nothing in this Act shall be construed to authorize the Secretary or the Board (or any of their agents or employees) to compel any person to undergo any medical screening, examination, diagnosis, or treatment, or to accept any other health care services provided under this Act for any purpose.

TITLE I—GENERAL PROVISIONS AND ADMINISTRATION

PART A—GENERAL PROVISIONS

DEFINITIONS

SEC. 101. For the purposes of this Act, the term—

(1) "Secretary" means the Secretary of Health, Education, and Welfare;

(2) "Board" means the Maternal and Child Health Board established by section 111;

(3) "child" means an individual from the time of birth to the age of eighteen years;

(4) "Council" means the National Maternal and Child Health Council established by section 121;

(5) "covered service" means a health care service or item described in title II for which payment may be made in accordance with title III of this Act; and

(6) "alien lawfully admitted for permanent residence" includes an alien permanently residing in the United States under color of law and an alien who is lawfully present in the United States as a result of the application of section 203 (a) (7) or section 212 (d) (5) of the Immigration and Nationality Act; and

(7) "State" includes the District of Columbia, the Commonwealth of Puerto Rico, and the territory of the Virgin Islands, Guam, and American Samoa.

ELIGIBILITY FOR BENEFITS

SEC. 102. (a) Every individual—

(1) who is a citizen of the United States or an alien lawfully admitted for permanent residence, and

(2) who is a child or who is pregnant,

shall be eligible to have payment made for health care services received by such individual in accordance with the provisions of this Act.

(b) Any female individual who is described in subsection (a) (1) shall be eligible to have payment for health care services received by such individual in order to determine whether or not such individual is pregnant, in accordance with the provisions of this Act.

PART B—ADMINISTRATION

ESTABLISHMENT OF THE MATERNAL AND CHILD HEALTH BOARD

SEC. 211. (a) There is hereby established in the Department a Maternal and Child Health Board to be composed of three members to be appointed by the President, by and with the consent of the Senate. During his term of membership on the Board, no member shall engage in any other business, vocation, or employment. Not more than two members of the Board shall be members of the same political party.

(b) Each member of the Board shall hold office for a term of five years except that—

(1) a member appointed to fill a vacancy occurring during the term for which his predecessor was appointed shall be appointed for the remainder of that term, and

(2) the terms of office of the members first appointed shall expire, as designated by the President at the time of their appointment, at the end of 1, 3, and 5 years, respectively, after the date of enactment of this Act.

A member who has served for two consecutive five-year

terms shall not be eligible for reappointment until two years after he has ceased to serve.

(c) The President shall designate one of the members of the Board as Chairman of the Board.

DUTIES OF THE BOARD

SEC. 112. (a) In addition to the specific duties given the Board under this Act, the Board shall—

(1) except as specifically provided under this Act, have the duty of administering titles II and III of this Act (relating to nature and scope of benefits and administration and method of payment of benefits under this Act), and

(2) have the general duty of continuously studying the operation of this Act and of the most effective methods of providing comprehensive personal health services to mothers and children in the United States, and of making recommendations on legislation and matters of administrative policy with respect thereto.

(b) The Board shall make an annual report to the Congress on the administration of the functions with which it is charged. The report shall include, for periods prior to the effective date of health benefits, an evaluation by the Board of the progress in preparing for the initiation of benefits under this Act, and for periods thereafter, an evaluation of the operation of the Act, of the adequacy and quality of serv-

ices furnished under it, of the adequacy of compensation to the providers of services, and of the costs of the services and the effectiveness of measures to control such costs.

(c) The Secretary shall make available to the Board all information available to him, from sources within the Department or from other sources, pertaining to the functions and duties of the Board.

EXECUTIVE DIRECTOR, EMPLOYMENT OF STAFF, AND DELEGATION OF AUTHORITY

SEC. 113. (a) There is hereby established the position of Executive Director of the Maternal and Child Health Board. The Executive Director shall be appointed by the Board with the approval of the Secretary and shall perform such duties in the administration of this Act as the Board assigns.

(b) (1) The Board is authorized to employ such individuals, in accordance with the provisions of title 5, United States Code, as may be necessary to carry out its functions under this Act.

(2) To the extent it deems it consistent with the purposes of this Act and its duties under this Act, the Board may employ such hearing examiners as it determines to be necessary to promote the resolution of disputes over

(1) an individual's eligibility for covered benefits under section 102;

(2) the qualifications of institutions, under section 202;

(3) the appropriateness of a fee payment schedule, prospective rate schedule, wholesale cost schedule, of dispensing fee schedule established under title III;

(4) the reasonableness of payments for special population benefits, under section 332; or

(5) violation of an agreement required under section 307 or the requirements of title III under section 307.

(c) The Board is authorized to delegate to the Executive Director, to any other officer or employee of the Board, or, with the approval of the Secretary, to any other officer or employee of the Department, any of its functions or duties under this Act, other than the issuance of regulations.

REGULATIONS OF AND SUBPENAS BY THE BOARD

SEC. 114. (a) The Board shall prescribe such regulations as may be necessary to carry out its duties under this Act.

(b) (1) For the purpose of any hearing, investigation, or other proceeding authorized under this Act, the Board may issue subpenas requiring persons any place in the United States to attend and testify as witnesses at the desig-

nated place of such hearing, investigation, or other proceeding, and to produce any evidence that relates to any matter under investigation or in question before the Board. Subpenas of the Board shall be served by anyone authorized by it by delivering a copy thereof to the person named therein, or by mailing a copy by registered mail or by certified mail addressed to such individual at his last dwelling place or principal place of business. A verified return by the individual so serving the subpena setting forth the manner of service, or, in the case of service by registered mail or by certified mail, the return post office receipt therefor signed by the person so served, shall be proof of service. Witnesses so subpenaed shall be paid the same fees and mileage as are paid witnesses in the district courts of the United States.

(2) In case of contumacy by, or refusal to obey a subpena duly served upon, any person, any district court of the United States for the judicial district in which such person charged with contumacy or refusal to obey is found or resides or transacts business, upon application by the Board, shall have jurisdiction to issue an order requiring such person to appear and give testimony, or to appear and produce evidence, or both; any failure to obey such order of the court may be punished by such court as contempt thereof.

FUNDS FOR THE EVALUATION OF THE MATERNAL AND CHILD HEALTH CARE PROGRAM

SEC. 115. (a) The Secretary shall allocate to the Office of Research and Statistics of the Social Security Administration an amount equal to one-tenth of 1 per centum of the total amount of payments made under this Act for the purpose of evaluating the operation of this Act and the impact of such operation on existing private health insurance programs.

(b) Not less often than annually, such Office shall report to the Secretary, to the Board, and to the Congress on the operation of this Act and shall include in such report any recommendations for changes in the operation of this Act.

PART C—ADVISORY COUNCIL

ESTABLISHMENT OF NATIONAL MATERNAL AND CHILD HEALTH COUNCIL

SEC. 121. (a) There is hereby established a National Maternal and Child Health Council, which shall consist of the Chairman of the Board, who shall serve as Chairman of the Council, and ten members, not otherwise in the employ of the United States, appointed by the Secretary, on recommendation of the Board, without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, as follows:

(1) not less than six individuals who—

(A) are not engaged in and have no financial interest in the furnishing of any health services,

(B) are representatives of consumers of maternal and child health care services,

(C) are familiar with the health care needs of mothers and children, and

(D) are experienced in dealing with problems associated with the obtaining of maternal and child health care services; and

(2) not more than four individuals who—

(A) are outstanding in fields related to medical, hospital, or other health activities, or

(B) are representative of organizations or associations of professional health personnel.

(b) Each member of the Council shall serve for a term of five years, except that—

(1) any member appointed to fill a vacancy occurring during the term for which his predecessor was appointed shall be appointed for the remainder of that term; and

(2) the terms of members first appointed shall expire, as designated by the Secretary at the time of their appointment, two at the end of the first year, two at the end of the second year, two at the end of the third year,

two at the end of the fourth year, and two at the end of the fifth year after the date of enactment of this Act.

DUTIES OF COUNCIL

SEC. 122. (a) The Council shall—

(1) advise the Board on matters of general policy in the administration of this Act, in the formulations of regulations, and in the performance of the Board's functions and duties,

(2) study the operation of this Act and the use of maternal and child health care services under it, and

(3) recommend to the Board such changes in the administration of the provisions of the Act as it deems desirable.

(b) The Council shall make an annual report to the Board on the performance of its functions, including any recommendations it may have with respect thereto, and shall promptly transmit such report to Congress.

(c) The Council shall meet as frequently as the Board deems necessary, but not less than four times each year. Upon request of six or more members, it is the duty of the Chairman to call a meeting of the Council.

APPOINTMENT OF STAFF AND COMPENSATION

SEC. 123. (a) The Council is authorized to appoint such professional or technical consultants as may be necessary to carry out its duties.

(b) The Board shall provide such secretarial, clerical, and other assistance as the Council may require to carry out its duties under this Act.

(c) Members of the Council and technical or professional consultants, while serving or traveling on business of the Council, shall receive compensation at rates fixed by the Board, but not in excess of the equivalent of the daily rate paid under GS–18 of the general schedule under section 5332 of title 5, United States Code; and while so serving away from their homes or regular places of business, they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, for persons in Government service employed intermittently.

TITLE II—NATURE AND SCOPE OF BENEFITS

PART A—DEFINITIONS AND QUALIFICATIONS OF INSTITUTIONS

DEFINITIONS, GENERAL TERMS AND SERVICES

SEC. 201. For the purpose of this title and title III, the term—

(1) "physician" means a doctor of medicine, osteopathy, dentistry, or optometry who is legally authorized to practice his or her profession in the State in which he or she performs such functions;

(2) "physician extender" means a physician assist-

ant, dental auxiliary, nurse practitioner, or nurse midwife under the supervision of a physician whether or not performed in the office of such physician or at a place at which he or she is present if the individual may legally perform the services in the State in which the services are performed;

(3) "professional services" means medical services provided by a physician or physician extender and includes materials and supplies commonly furnished, without separate charge, by a physician or physician extender as an incident to the provision of such services;

(4) "preventive children's health services" means professional services the frequency and content of which are determined by the Board, after consultation with the Council, to be ordinarily necessary to maintain the health of a child and to prevent common illnesses, and may include medical and dental evaluations, immunizations, screening for vision and hearing defects, and appropriate health education;

(5) "inpatient services" means—

(A) bed and board;

(B) such nursing, medical, rehabilitative, and other services as are ordinarily furnished by a qualified hospital for the care and treatment of inpatients;

(C) such mental health services, including psy-

chiatric and psychological services, only as are incident to the treatment of conditions other than psychosis;

(D) drugs, biologicals, blood and blood products, supplies, appliances, and equipment for use in a hospital for the care and treatment of inpatients; and

(E) such other diagnostic and therapeutic items and services ordinarily furnished by a qualified hospital, or by others by arrangement with such hospital, to inpatients.

(6) "home health services" means nursing services and home-making services, as defined by the Board;

(7) "diagnostic services" means tests for the purpose of providing information for the diagnosis, prevention, or treatment of any injury, disability, or disease or for the assessment of the health of an individual;

(8) "emergency medical care" means medical care for patients with a severe, life-threatening, or potentially disabling condition which requires medical intervention within minutes or hours after the onset of such condition; and

(9) "support services" means services described in section 233.

STANDARDS FOR QUALIFIED INSTITUTIONS

SEC. 202. For the purposes of this title and title III, the term—

(1) "qualified hospital" means a hospital which, as determined in accordance with section 203—

(A) provides diagnostic and therapeutic services to patients for a variety of medical conditions;

(B) maintains clinical records on all its patients;

(C) has bylaws in effect with respect to its staff of physicians;

(D) has taken steps to ensure that it will not discriminate on any ground unrelated to professional qualifications in the granting or maintaining of medical staff privileges;

(E) requires that every patient must be under the direct and personal care of a single physician;

(F) provides twenty-four-hour nursing service rendered or supervised by a registered professional nurse, and has a licensed practical nurse or registered professional nurse on duty at all times;

(G) has a pharmaceutical and drug therapeutics committee which establishes policies for the selection, acquisition, and use of drugs;

(H) has in effect a hospital utilization review

plan which meets the requirements of title XVIII of the Social Security Act;

(I) meets all applicable requirements of the laws of the State and of the locality in which it is situated; and

(J) meets such other requirements as the Board finds necessary in the interest of the health and safety of the individuals who are furnished services in such institution.

(2) "qualified pediatric unit" means a unit in a qualified hospital which, as determined in accordance with section 203—

(A) is a separate unit in the hospital for the exclusive use of children;

(B) contains at least twelve beds;

(C) has an annual occupancy rate of at least 70 per centum;

(D) has no restrictions on visiting hours for parents and guardians except as medically required; and

(E) has a reasonable and adequate arrangement for overnight accommodation of the parent, guardian, or adult friend of a patient under the age of seven years.

(3) "qualified obstetrical unit" means a unit in a

qualified hospital which, as determined in accordance with section 203—

(A) is a separate unit in the hospital for the exclusive use of obstetrical patients;

(B) has an average of at least—

(i) 500 deliveries annually if located in a rural area (as defined by the Board), or

(ii) 1,500 deliveries annually if not located in a rural area.

The Board may waive the required number of deliveries specified in subparagraph (B) (i) if it finds it in the best interests of the medical care of pregnant women in the area.

(4) "qualified nursing home" means an institution which, as determined in accordance with section 203—

(A) provides skilled nursing and related services to inpatients who are not being treated primarily for mental illness;

(B) has written policies, established and periodically reviewed by a group including at least one physician and at least one registered nurse, governing its furnishing of health services, including the dispensing and administering of drugs;

(C) has a full-time physician or full-time regis-

tered nurse supervising its furnishing of medical services;

(D) requires that every patient must be under the direct and personal care of a single physician;

(E) has a physician available to furnish emergency medical care;

(F) maintains clinical records on all its patients;

(G) has in effect a utilization review plan which meets the requirements of title XVIII of the Social Security Act;

(H) meets all applicable requirements of the laws of the State and of the locality in which it is situated;

(I) provides for examination of a patient by a physician within twenty-four hours of the time of his admission to it;

(J) provides for admission of a patient only after a certification by a physician that the patient requires care in such a facility; and

(K) meets such other requirements as the Board finds necessary in the interest of the health and safety of the individuals who are furnished services in such institution.

(5) "qualified home health agency" means an institution which, as determined in accordance with section 203—

(A) is a public or nonprofit organization, or subdivision thereof;

(B) provides skilled nursing related to patients in their homes;

(C) has written policies, established and periodically reviewed by a group including at least one physician and at least one registered nurse, governing its furnishing of services;

(D) has a full-time physician or full-time registered nurse supervising its furnishing of home health services;

(E) maintains clinical records on all its patients;

(F) meets all applicable requirements of the laws of the States and of the localities in which it furnishes services; and

(G) meets such other requirements as the Board finds necessary in the interest of the health and safety of the individuals who are furnished services in such institution.

(6) "qualified pathology laboratory" means a fa-

cility for the biological, microbiological, serological, chemical, immuno-hematological, hematological, biophysical, cytological, pathological, or other examination of materials derived from the human body, which meets all applicable requirements of the laws of the State and of the locality in which it is situated.

DETERMINATION OF QUALIFIED INSTITUTIONS

SEC. 203. (a) In determining the qualifications of an institution under section 202, the Board shall consult, pursuant to this section, with appropriate State agencies, recognized national listing or accrediting bodies, and health systems agencies (established pursuant to title XV of the Public Health Service Act).

(b) (1) The Board shall delegate, to the extent that the Board finds it appropriate, to a State health agency or other appropriate State agency (hereinafter in this subsection referred to as the "State health agency"), the function of determining whether or not an institution meets any or all of the qualifications of section 202.

(2) If the Board finds that accreditation of an institution by the Joint Commission on Accreditation of Hospitals, the American Osteopathic Association, or any other national accrediting body provides reasonable assurance that any or

all of the qualifications of section 202 are met, it may, to the extent it deems it appropriate, treat such institution or agency as meeting the qualification or qualifications with respect to which the Board made such finding.

(3) The Board may agree with the State health agency for such agency to survey—

(A) on a selective sample basis, or

(B) when the Board finds that a survey is appropriate because of substantial allegations of the existence of a significant deficiency or deficiencies, which, if found to be present, would adversely affect the health and safety of patients,

any institution whose qualifications under section 202 are reviewed under subsection (b) (2) or section 303 (a) (2) (A), and which has made an agreement with the Board pursuant to section 321 (b) (3).

(4) No later than sixty days after the completion, pursuant to paragraph (1) or (3), of a survey by a State health agency of the qualifications of an institution under this Act, the Board shall publish the findings of each such survey in a readily available manner.

(c) The Board shall pay the State health agency for the reasonable cost of performing functions authorized under subsection (b).

PART B—CHILDREN'S BENEFITS

COVERED PROFESSIONAL SERVICES

SEC. 211. (a) Except as provided in subsection (b), covered professional services shall include—

(1) preventive children's health services, and

(2) professional services for the diagnosis, treatment, or rehabilitation of a child following injury, disability, or disease.

(b) For the purposes of this section, covered professional services do not include—

(1) orthodontic services for children except for handicapping malocclusion;

(2) professional dental services for children under the age of four years;

(3) major surgery on a child not performed by a surgeon eligible or certified by a surgical specialty board;

(4) a tonsillectomy or adenoidectomy performed on a child without a second consultation by an independent physician as to the necessity for such surgery; and

(5) psychiatric services.

COVERED INPATIENT HOSPITAL SERVICES

SEC. 212. (a) Except as provided in subsections (b) and (c), covered inpatient hospital services shall include—

(1) inpatient services for a child of any age in any qualified hospital where a physician certifies, in accordance with regulations established by the Board, that the child requires emergency medical care;

(2) inpatient services for a child under the age of twelve years in a qualified pediatric unit; and

(3) inpatient services for a child of twelve years or older in a qualified hospital.

(b) For the purposes of this section, covered services do not include the services of a private duty nurse or attendant.

(c) Covered inpatient hospital services under this section are limited to 100 days of inpatient services annually.

COVERED NURSING HOME SERVICES

SEC. 213. (a) Except as provided in subsection (b), covered nursing home services shall include inpatient services for a child in any qualified nursing home.

(b) Covered nursing home services under this section are limited to 120 days of inpatient services annually.

COVERED HOME HEALTH CARE SERVICES

SEC. 214. (a) Except as provided in subsection (b), covered home health care services shall include home health care services furnished by a qualified home health agency, where a physician certifies, in accordance with regulations

established by the Board, that such services are necessary for the health and welfare of a child.

(b) Covered home health care services under this section are limited to 120 days of home health care services annually.

COVERED DIAGNOSTIC SERVICES

SEC. 215. Covered diagnostic services shall include diagnostic services performed by a qualified pathology laboratory for a child who is not an inpatient in a hospital or in a nursing home.

COVERED REHABILITATIVE, SOCIAL, AND MENTAL HEALTH SERVICES

SEC. 216. (a) Except as provided in subsection (b), covered rehabilitative, social, and mental health services shall include—

(1) rehabilitative services, including physical therapy and speech therapy,

(2) social services, and

(3) mental health services, including psychiatric and psychological services,

furnished to a child who is not an inpatient in a hospital or nursing home, if furnished in a facility described in subsection (c), where a physician certifies, in accordance with

regulations established by the Board, that such services are necessary for the health and welfare of a child.

(b) Covered rehabilitative, social, and mental health services under this section are limited as follows:

(1) rehabilitative services are limited to 60 visits, as defined by the Board, annually, and

(2) social and mental health services are limited to 60 visits, as defined by the Board, annually.

(c) A service described in subsection (a) is a covered service when furnished in a facility which—

(1) is run by a nonprofit or public organization, or subdivision thereof, and

(2) meets the applicable requirements of laws of the State and of the locality in which it is located.

COVERED DRUGS AND BIOLOGICALS

SEC. 217. (a) Covered drugs and biologicals shall include any drug or biological dispensed for use by a child who is not an inpatient in a hospital or nursing home, if—

(1) such drug or biological is required, by section 503 (b) of the Federal Food, Drug, and Cosmetic Act, to be dispensed only upon prescription of a physician; and

(2) such drug or biological is prescribed to be taken by such child for a period of longer than four weeks.

(b) Covered drugs and biologicals shall also include insu-

lin dispensed for use by a child who is not an inpatient in a hospital or nursing home.

COVERED DEVICES, APPLIANCES, AND EQUIPMENT

SEC. 218. (a) Except as provided in subsection (b), covered devices, appliances, and equipment shall include—

(1) the dispensing of such devices for the correction of the vision or hearing of a child, and

(2) the dispensing of such other medical devices, appliances, and equipment for the treatment or rehabilitation of a child following injury, disability, or disease, as a physician certifies, in accordance with regulations established by the Board, to be necessary for the health and welfare of such child.

(b) The Board may, by regulation, exclude from covered devices, appliances, and equipment under subsection (a) the dispensing of such devices, appliances, and equipment as the Board determines to be ineffective, unreliable, or not cost-justified in the treatment or rehabilitation of a child following injury, disability, or disease.

PART C—MATERNITY BENEFITS

COVERED PROFESSIONAL SERVICES

SEC. 221. Covered professional services shall include professional services—

(1) for the diagnosis and treatment of pregnancy, and

(2) for the diagnosis and treatment of any injury, disability, or disease during pregnancy, and

(3) for the diagnosis and treatment of any injury, disability, or disease related to pregnancy during the period of twelve weeks immediately following the termination of a pregnancy.

COVERED INPATIENT HOSPITAL SERVICES

SEC. 222. (a) Except as provided in subsection (b), covered inpatient hospital services shall include—

(1) inpatient services for a woman during pregnancy in any qualified hospital where a physician certifies, in accordance with regulations established by the Board, that the woman requires emergency medical care;

(2) inpatient services in a qualified hospital for a woman during the period of twelve weeks immediately following the termination of her pregnancy where a physician certifies, in accordance with regulations established by the Board, that the woman requires emergency medical care for the diagnosis or treatment of any injury, disability, or disease related to pregnancy; and

(3) inpatient services for a woman during pregnancy in any qualified obstetrical unit.

(b) For the purposes of this section, covered inpatient

hospital services do not include the services of a private duty nurse or attendant.

COVERED DIAGNOSTIC SERVICES

SEC. 223. (a) Covered diagnostic services shall include diagnostic services performed by a qualified pathology laboratory—

(1) for a woman during pregnancy, and

(2) for a woman during the period of twelve weeks immediately following the termination of pregnancy, if such woman is not an inpatient in a hospital or in a nursing home.

(b) Covered diagnostic services shall include diagnostic services performed by a qualified pathology laboratory to determine whether or not a woman is pregnant.

COVERED DRUGS AND BIOLOGICALS

SEC. 224. Covered drugs and biologicals shall include any drug or biological dispensed for use by a woman during pregnancy or during the period of twelve weeks immediately following the termination of her pregnancy, if such woman is not an inpatient in a hospital or nursing home, and if—

(1) such drug or biological is required, by section 503 (b) of the Federal Food, Drug, and Cosmetic Act, to be dispensed only upon prescription of a physician;

and such drug or biological is prescribed to be taken by such woman for a period of longer than four weeks, or

(2) such drug is insulin.

COVERED DEVICES, APPLIANCES, AND EQUIPMENT

SEC. 225. (a) Except as provided in subsection (b), covered devices, appliances, and equipment shall include the dispensing of such devices, appliances, and equipment as a physician may certify, in accordance with regulations established by the Board, as required for the treatment of a woman for any condition related to pregnancy during pregnancy or during the period of twelve weeks immediately following the termination of her pregnancy.

(b) The Board may, by regulation, exclude from covered devices, appliances, and equipment under subsection (a) the dispensing of such devices, appliances, and equipment as the Board determines to be ineffective, unreliable, or not cost-justified in the treatment of a condition related to pregnancy.

PART D—SPECIAL POPULATION BENEFITS

PURPOSE

SEC. 231. The purpose of this part is to furnish additional covered support services to individuals residing in inaccessible areas or who are otherwise unlikely to use the other services covered under this Act in order to promote the appropriate use of services under this Act by all indi-

viduals, regardless of race, income, health status, or location of residency.

SPECIAL POPULATION

SEC. 232. (a) The Board to the maximum extent feasible shall arrange for the furnishing of the covered support services, described in section 233, to individuals—

(1) who reside in a medically underserved area, as determined by the Board, or

(2) who, because of poverty, discrimination, or cultural barriers, are determined by the Board to suffer a higher risk of infant and maternal morbidity and mortality than other individuals.

(b) For the purposes of subsection (a), the term "medically underserved area" means an area with a shortage of persons furnishing professional services or inpatient services.

COVERED SUPPORT SERVICES

SEC. 233. (a) Covered support services shall include, with respect to an individual described in section 232 (a)—

(1) transportation of such individual (and, if such individual is a child, the parent or guardian of such child) to and from a person furnishing covered services to such individual under this Act;

(2) care of a dependent while such individual is being furnished covered services under this Act;

(3) social outreach assistance to inform such individual about and to assist such individual in receiving covered services furnished under this Act; and

(4) such similar services provided on behalf of such individual as the Board determines as necessary and appropriate to the purposes of this part,

if such services are provided by a person described in subsection (b).

(b) A support service described in subsection (a) is a covered service when furnished—

(1) under the supervision of a qualified institution, or

(2) by or under the supervision of a public or private nonprofit organization determined by the Board to have the organizational and financial capability to furnish such service on a dependable and fiscally responsible basis.

TITLE III—ADMINISTRATION AND METHOD OF PAYMENT OF BENEFITS

PART A—ADMINISTRATION AND GENERAL PROVISIONS

DEFINITIONS

SEC. 301. For the purposes of this title, the term—

(1) "carrier" means a voluntary association, corporation, partnership, or other nongovernmental organization which is lawfully engaged in providing, paying for, or reimbursing the cost of, health services under

group insurance policies or contracts, medical or hospital service agreements, membership or subscription contracts, or similar group arrangements, in consideration of premiums or other periodic charges payable to the carrier, including a health benefits plan duly sponsored or underwritten by an employee organization;

(2) "fee payment area" means an area designated by the Secretary, pursuant to section 1152(a) of the Social Security Act (42 U.S.C. 1320c–1), as appropriate with respect to the establishment of Professional Standards Review Organizations;

(3) "fee payment schedule" means a schedule, approved in accordance with section 312, of the amount of payments for the provision under this Act of various covered professional services;

(4) "covered institutional services" means—

(A) covered inpatient hospital services,

(B) covered nursing home services,

(C) covered home health care services,

(D) covered rehabilitative, social, and mental health services, and

(E) covered diagnostic services;

(5) "qualified institution" means—

(A) a qualified hospital,

(B) a qualified nursing home,

(C) a qualified home health agency,

(D) a facility described in section 216 (a) (3), and

(E) a qualified pathology laboratory;

(6) "prospective rate schedule" means a schedule, approved in accordance with section 322, of the amount of payments for the provisions under this Act of various covered institutional services; and

(7) "person" includes a qualified institution.

DELEGATION OF SECRETARY'S AUTHORITY

SEC. 302. To the extent he deems it consistent with the purposes of this Act, the Secretary may delegate his authority for the administration of the system of payments for benefits provided for in this title to the Administrator of the Social Security Administration.

USE OF CARRIERS FOR ADMINISTRATION OF BENEFITS

SEC. 303. (a) In order to provide for the administration of the benefits under this Act with maximum efficiency and convenience for individuals eligible for benefits under this Act and for persons furnishing services to such individuals, the Secretary is authorized, after consultation with the Board, to enter into contracts with carriers to perform some or all of the following functions (or, to the extent provided in such contracts, will secure performance thereof by other organizations)—

(1) (A) determine the amounts of payments required to be made under this Act;

(B) receive, disburse, and account for funds in making such payments;

(C) assist persons furnishing services under this Act in establishing and maintaining fiscal records necessary for purposes of this Act; and

(D) make such audits of the records of persons furnishing services as may be necessary to assure that proper payments are made under this Act;

(2) (A) determine compliance with the qualifications of section 202, and

(B) assist persons who furnish services for which payment may be made under this Act, in the development of procedures relating to utilization practices, make studies of the effectiveness of such procedures and methods for their improvement, assist in the application of safeguards against unnecessary utilization of services furnished by persons to individuals eligible for benefits under this Act, and provide procedures for and assist in arranging where necessary, the establishment of groups outside hospitals (meeting the requirements of section 1861 (k) (2) of the Social Security Act) to make reviews of utilization;

(3) serve as a channel of communication of information relating to the administration of this Act; and

(4) otherwise assist, in such manner as the contract may provide, in discharging administrative duties necessary to carry out the purposes of this Act.

(b) (1) Contracts with carriers under subsection (a) may be entered into without regard to section 3709 of the Revised Statutes or any other provision of law requiring competitive bidding.

(2) No such contract shall be entered into with any carrier unless the Secretary finds that such carrier will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, and other matters as he finds pertinent.

(c) Each such contract shall provide that—

(1) where the carrier has agreed to make payments under this Act—

(A) the carrier shall establish and maintain procedures by which a person furnishing services covered under this Act will be granted an opportunity for a fair hearing by the carrier, in any case where the amount in controversy is $100 or more—

(i) when requests for payment for such

services under this Act are denied or are not acted upon with reasonable promptness, or

(ii) when the amount of such payment is in controversy;

(B) the carrier shall use such standard forms and procedures for requests for payment as the Board may prescribe to minimize administrative work of physicians and others furnishing services covered under this Act;

(C) the Secretary shall advance funds to the carrier for the making of payments under this Act; and

(2) the carrier shall furnish to the Secretary such timely information and reports as he may find necessary in performing his functions under this Act; and

(3) the carrier shall maintain such records and afford such access thereto as the Secretary finds necessary to assure the correctness and verification of the information and reports under paragraph (2) and otherwise to carry out the purposes of this Act;

and shall contain such other terms and conditions not inconsistent with this section as the Secretary may find necessary or appropriate.

(c) (1) Except as provided in paragraph (2), each

contract shall be for a term of at least two years, and may be made automatically renewable from term to term in the absence of notice by either party of its intention not to renew the contract at the end of the current term.

(2) Each contract may be terminated—

(A) by the carrier at such time and upon such notice to the Secretary, to the Board, to the public, and to persons furnishing services under this Act, as the Secretary establishes by regulation, and

(B) by the Secretary at any time, after such reasonable notice to the carrier, the Board, the public, and to persons furnishing services under this Act and after such opportunity for a hearing to the carrier as the Secretary establishes by regulation, if the Secretary finds that—

(i) the carrier has failed substantially to carry out the contract, or

(ii) the carrier is carrying out all or some of the duties provided for in the contract in a manner inconsistent with the effective and efficient administration of this Act.

(d) (1) Any contract with a carrier under this section may require such carrier or any of its officers or employees certifying payments or disbursing funds pursuant to the contract, or otherwise participating in carrying out the con-

tract, to give surety bond to the United States in such amount as the Secretary may deem appropriate.

(2) No individual designated pursuant to a contract under this section as a certifying officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payments certified by him under this section.

(3) No individual designated pursuant to a contract under this section as a disbursing officer shall, in the absence of gross negligence or intent to defraud the United States, be liable, with respect to any payment by him under this section if it was based upon a voucher signed by an individual designated pursuant to a contract under this section as a certifying officer.

(4) No such carrier shall be liable to the United States for any payments referred to in paragraph (2) or (3).

LIMITATION ON PAYMENTS

SEC. 304. (a) Payment for a covered service furnished under this Act may be made only—

(1) to the person furnishing such service,

(2) to the employer of such person, if such person has an agreement to turn over such payments to his employer, or

(3) to the facility in which such service was provided, if there is an agreement between such person and

facility under which the facility receives payments for such person's services.

(b) No payment may be made for covered institutional services furnished by a person prior to the Board's determination that such person is a qualified institution.

REQUIREMENT OF COPAYMENT FOR CERTAIN COVERED SERVICES

SEC. 305. (a) The Secretary shall pay 100 per centum of the full payment amount if—

(1) such covered service is other than one of the following:

(A) a home health service;

(B) a covered device, equipment, or appliance, described in section 218 or 225, or

(C) a covered professional service, other than preventive children's health services, furnished to a child; or

(2) such covered service is furnished under a fee schedule described in section 312 (a) (2) (relating to capitation methods); or

(3) the individual to whom such covered service is furnished (or if the individual is a child, the parent or guardian of such child)—

(A) has an income below the poverty level, as determined by the Board, or

(B) is eligible in the State in which he resides for any benefits under title XIX of the Social Security Act (relating to medicaid).

(b) Except as provided in subsection (a), the Secretary shall pay 90 per centum of the full payment amount.

(c) For the purposes of this section, the term "full payment amount" means the amount specified in a schedule established pursuant to this title as representing full payment for the furnishing of any covered service.

SIMPLIFIED REQUEST FOR PAYMENT PROCEDURES

SEC. 306. The Secretary and the Board shall provide, to the extent consistent with the efficient administration of this Act, for the consolidation and standardization of simple forms and procedures which a physician, physician extender, or qualified institution must complete in order to request and receive payment for furnishing covered professional and institutional services under this Act.

PROHIBITION OF AND CONDITIONS FOR PAYMENTS

SEC. 307. (a) If the Board determines, after a hearing, held in accordance with subchapter II of chapter 5 of title 5, United States Code (Administrative Procedure Act), that a person furnishing covered services under this Act has—

(1) substantially or consistently violated the terms of an agreement required under the provisions of this title, or

(2) has substantially or consistently violated requirements for such person under this title,

the Board may prohibit, for such period, not to exceed one year, as it may deem appropriate, the making of any payments under this Act with respect to the furnishing of covered services by such person after the determination by the Board.

(b) If the Board determines, after a hearing held in accordance with subchapter II of chapter 5 of title 5, United States Code (Administrative Procedure Act), that a person furnishing covered services under this Act has violated an agreement containing the provisions of section 311(c)(2), 311(d)(1)(A), 311(d)(2), 321(b)(2), 321(c)(2), 332(c)(2), or 332(d)(1), the Board may require, as a condition for such person having payments made under this Act for services furnished after the date of such determination, that such person provide an appropriate arrangement for the refunding of those fees and charges which were collected in violation of the applicable provisions of such sections.

PART B—PAYMENT FOR COVERED PROFESSIONAL SERVICES

GENERAL PROVISIONS

SEC. 311. (a) Payments shall be made by the Secretary for the furnishing of covered professional services in accordance with part A and this part.

(b) (1) In accordance with procedures established by

the Secretary, after consultation with the Board, any person intending to request payment for its furnishing of covered professional services under this Act shall notify the Secretary of such intention at least thirty days prior to submittal of the first request for payment for such person.

(2) The Board shall make available, in such manner and form and at such times as the Board may consider appropriate, to the public the name, address, and telephone number of each person who has filed, pursuant to paragraph (1), notice of his intent to request payment for the furnishing of covered professional services under this Act.

(c) Any person furnishing covered professional services who intends to request payment under this Act for furnishing such services shall—

(1) display, in a manner prescribed by the Board, public notice of its participation in the program under this Act; and

(2) inform each patient (or if the patient is a child, the parent or guardian of such patient), prior to the furnishing of such services, the amount of any co-payment the patient (or parent or guardian of such patient) must make for such services.

(d) (1) No payment shall be made pursuant to this Act to a person furnishing a covered professional service unless that person agrees—

(A) except as provided in section 313, to accept the amount specified in the appropriate fee payment schedule, established in accordance with section 312, as full payment for such services, and

(B) to provide such information, as the Secretary may require by regulation, to verify the service or services furnished.

(2) No payment shall be made pursuant to a fee payment schedule described in section 312 (a) (2) (relating to capitation payments) unless the person receiving payment pursuant to such schedule furnishes in an appropriate manner, determined by the Board, all services covered under such schedule, or has arranged, in an appropriate manner, determined by the Board, for the furnishing of all such services as it is not qualified to furnish.

(e) (1) Timely payment under this Act based on a fee payment schedule described in section 312 (a) (1) (relating to fee for service) shall be made in accordance with this Act after the furnishing of the service covered in such schedule.

(2) Timely payment under this Act based on a fee payment schedule described in section 312 (a) (2) (relating to capitation fees) shall be made in such a manner, to be determined by the Board, as to reflect the timing of normal furnishing of services to individuals receiving the care described in such section under this Act.

APPROVAL OF FEE PAYMENT SCHEDULES

SEC. 312. (a) In accordance with this section, the Board shall approve for each fee payment area a schedule of the amount of payments to be made under this Act for the furnishing of various covered professional services, and shall include—

(1) a fee payment schedule for the furnishing of individual services, and

(2) a fee payment schedule for the payment—

(A) of a single amount for the furnishing of prepaid pediatric care (as defined in subsection (f) (1)) for a period of not less than one year, as specified by the Board, and

(B) of a single amount for the furnishing of prepaid maternity care (as defined in subsection (f) (2)).

(b) For the purposes of this section, the Board shall designate for each fee payment area a fee payment board (hereinafter in this section referred to as the "fee payment board") which shall be—

(1) a nonprofit organization (or component thereof),

(2) composed of individuals furnishing covered professional services in such area, and

(3) open for membership to all individuals furnishing such professional services in such area.

(c) Each fee payment board shall submit to the Board a proposed fee payment schedule no later than 18 months after the date of enactment of this Act. Each such board may submit to the Board a proposed revision of such schedule once every year and at such other times as the Board, after consultation with the Secretary, may deem appropriate to the administration of this Act.

(d) (1) The Board shall approve a proposed fee payment schedule or a proposed revision thereof if it finds that such schedule or revision, except as provided in paragraph (2), reflects the prevailing fee for service or services in the fee payment area as of December 31, 1974, as adjusted according to such economic index or indices as the Board determines to be appropriate.

(2) A fee schedule described in subsection (a) (2) (relating to capitation payments) may provide for the payment of an amount, not to exceed by more than 10 per centum the amount otherwise payable under this subsection, in addition to the amount otherwise payable under this subsection.

(3) Where a fee payment schedule has not been proposed for a fee payment area, or where the Board does not

approve a proposed schedule, the Board shall approve as a fee payment schedule for such area—

(A) a schedule which reflects an approved schedule for an area similar in economic characteristics to the area involved, or

(B) where the Board determines that an area of similar economic characteristics does not exist, a schedule which, except as provided in paragraph (2) of this subsection, reflects the prevailing fee for service or services in the fee payment area as of December 31, 1974, as adjusted according to such economic index or indices as the Board determines to be appropriate.

(4) No later than one month before approval of a proposed schedule, and within one month after approval of a schedule, the Board shall publish notice of such schedule in the fee payment area covered by such schedule.

(e) Persons adversely affected by the Board's approval or disapproval of a fee payment schedule under this section may seek review of such approval or disapproval under the procedures provided in subchapter II of chapter 5 of title 5, United States Code (Administrative Procedure Act).

(f) As used in this section, the term—

(1) "prepaid pediatric care" means covered professional services under section 211 including—

(A) preventive children's health services, and

(B) such other health services as may be determined by the Board as appropriate for the diagnosis and treatment of common pediatric conditions; and

(2) "prepaid maternity care" means such covered professional services under section 221 as the Board determines are ordinary and appropriate in a normal maternity case.

DEMONSTRATION METHODS OF PAYMENT

SEC. 213. (a) In lieu of payment pursuant to section 312, a fee payment board may propose and the Board may approve, on an experimental or demonstration basis for a period not to exceed two years, a method of payment for covered professional services furnished under this Act, if the Board determines that the total amount of payments under such method will not exceed the total amount of payments which would otherwise be made under the applicable fee payment schedule.

(b) The Board shall report to Congress on the results of any experiments or demonstrations under subsection (a),

and include in such report such recommendations for changes in the methods of payment under this Act as the Board determines are appropriate.

PART C—PAYMENT FOR COVERED INSTITUTIONAL SERVICES

GENERAL PROVISIONS

SEC. 321. (a) Payments shall be made on a timely basis and in accordance with part A and this part by the Secretary for covered institutional services.

(b) No payment shall be made under this Act to a qualified institution furnishing covered institutional services unless such institution—

(1) has submitted and has had approved by the Board a prospective rate schedule, in accordance with section 322;

(2) agrees to accept the amount specified in such schedule as full payment for such services; and

(3) agrees to provide such information, as the Secretary may require by regulation, to verify its qualifications as a qualified institution and to verify the services furnished under this Act.

(c) Any qualified institution which has had a prospective rate schedule, for its furnishing of covered institutional

services, approved pursuant to section 322, and which intends to request payment under this Act for furnishing such services shall—

(1) display, in a manner prescribed by the Board, public notice of its participation in the program under this Act, and

(2) inform each patient (or if patient is a child, the parent or guardian of such patient), prior to the furnishing of such services, the amount of any copayment the patient (or parent or guardian of such patient) must make for such services.

APPROVAL OF PROSPECTIVE RATE SCHEDULES

SEC. 322. (a) (1) The Board, after consultation with the Secretary, qualified institutions, carriers, and other interested parties and organizations, shall establish one or more methods (hereinafter in this section referred to as "methods"), which satisfy the criteria of subsection (b), for the establishment of a prospective rate schedule for the payment of qualified institutions furnishing covered institutional services under this Act.

(2) The Board may modify or eliminate a method or methods established under paragraph (1) where it determines, after consultation with qualified institutions which have submitted to the Board a proposed prospective rate

schedule based on such method, and with the Secretary, carriers, and other interested parties and organizations, that—

(A) such method or methods are inconsistent with the provisions of subsection (b), or

(B) are inconsistent with the efficient administration or purposes of this Act.

(3) Any modification or elimination of a method or methods pursuant to paragraph (2) shall take effect, with respect to a qualified institution which has submitted to the Board a proposed prospective rate schedule based on such method, no earlier than six months after the Board has notified such institution of such modification or elimination of such method or methods.

(b) Any method established by the Board pursuant to subsection (a) for payment of qualified institutions for furnishing covered institutional services shall provide—

(1) for the establishment of rates of payment for such services in advance of the time when such services are furnished and without regard to costs actually incurred in furnishing such services;

(2) for the revision of such rates no more frequently than once every year, unless the Board determines that more frequent adjustments are appropriate due to significant unforeseeable events, including—

(A) natural disasters and catastrophes,

(B) epidemics,

(C) major economic dislocations not under the control of the institution furnishing such services, and

(D) significant changes in patient mix not under the control of the institution furnishing such services;

(3) financial incentives for improved efficiency in the furnishing of such services by sharing savings with qualified institutions that perform at lower than anticipated costs;

(4) incentives for improved quality in the furnishing of covered services;

(5) for a reasonable return on investment based on a rate of return on investment of comparable risk and computed at the time such prospective rate schedule is established; and

(6) for payment of such portion of the operation and administration (including the financing of capital improvements), of such qualified institution's program as is necessary for the furnishing of such services, and, if subject to review by a health systems agency under section 1513 (e) (1) (A) of the Public Health Services Act, as has been approved by such agency.

(c) Each person who intends to request payment for the furnishing of covered institutional services pursuant to this Act—

(1) shall submit to the Board a proposed prospective rate schedule for the furnishing of such services based on a method established by the Board pursuant to this section, and

(2) may submit to the Board, after such schedule has become effective, a proposed revision of such schedule—

(A) once every year,

(B) when the Board modifies or eliminates a method, pursuant to subsection (a) (2), upon which such schedule has been based, and

(C) at such other times as the Board, after consultation with the Secretary, determines is consistent with subsection (b) (2) and is appropriate for the administration of this Act.

(d) (1) Unless the Board, no later than sixty days after the date of the submittal of a proposed prospective rate schedule or a proposed revision thereof, finds that such schedule or revision is inconsistent with a method established by the Board, such schedule or revision thereof shall become effective sixty days after the date of such submittal.

(2) No later than ten days after the date a proposed

rate schedule or a revision thereof is submitted to the Board, the person submitting the proposal shall publish such proposed schedule or revision in such region affected by the proposal and in such a manner as the Board may determine is appropriate to carry out the purposes of this Act.

(e) Persons adversely affected by the Board's approval or disapproval of a prospective rate schedule or revision thereof under this section may seek review of such approval or disapproval under the procedures provided in subchapter II of chapter 5 of title 5, United States Code (Administrative Procedure Act).

PART D—PAYMENT FOR DRUGS, DEVICES, AND SPECIAL POPULATION BENEFITS

DEFINITIONS

SEC. 331. As used in this part, the term—

(1) "dispenser" means any person who has notified the Secretary, pursuant to section 332(b)(1), of his intention to request payment under this Act for the dispensing of covered drugs and devices; and

(2) "covered drugs and devices" means covered drugs and biologicals, and covered devices, appliances, and equipment.

PAYMENT FOR COVERED DRUGS AND DEVICES

SEC. 332. (a) Payments shall be made by the Secretary for the dispensing of covered drugs and devices in accordance with part A and this part.

(b) (1) In accordance with procedures established by the Secretary, after consultation with the Board, any person intending to request payment for its dispensing of covered drugs and devices under this Act shall notify the Secretary of such intention at least thirty days prior to submittal of the first request for payment for such person.

(2) The Board shall make available, in such manner and at such times as the Board may consider appropriate, to the public the name, address, and telephone number of each dispenser.

(c) Each dispenser shall—

(1) display, in a manner prescribed by the Board, public notice of its participation in the program under this Act; and

(2) inform each patient (or if the patient is a child, the parent or guardian of such patient), prior to the dispensing of such drugs or devices, the amount of any copayment the patient (or the parent or guardian of such patient) must make for such drugs or devices.

(d) No payment shall be made pursuant to this Act to a dispenser unless that person agrees—

(1) to accept the amount specified in accordance with subsection (e), as full payment for the dispensing of such drug or device, and

(2) to provide such information, as the Secretary

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may require by regulation, to verify the drug or device dispensed.

(e) The amount of payment made under this Act for the dispensing of a covered drug or device shall be the sum of—

(1) the wholesale cost of such drug or device, as determined under the schedule adopted pursuant to subsection (f), and

(2) a fee for the dispensing of such drug or device (hereinafter in this section referred to as a "dispensing fee"), as determined under the schedule adopted pursuant to subsection (g).

(f) (1) The Board shall determine and publish, no less often than annually, a schedule of the wholesale cost of covered drugs and devices commonly dispensed under this Act, and shall establish by regulation procedures for determination of the wholesale cost of covered drugs and devices not commonly dispensed under this Act.

(2) The Board may provide in such schedule for variations in the wholesale cost to reflect differences in costs to a dispenser as a result of differences in size of the dispenser and differences in the regional location of the dispenser.

(g) (1) A dispenser requesting payment under this part shall submit to the Board, in a form prescribed by the Board, a proposed schedule of dispensing fees.

(2) Such schedule may be revised once every year and

at such other times as the Board, after consultation with the Secretary, determines is consistent with the administration of this Act.

(3) The Board shall approve such proposed schedule or proposed revision thereof unless, no later than sixty days after the submittal of such proposed schedule or of a proposed revision thereof, it finds that the dispensing fees in such schedule or revision are not in excess of a percentage of the schedule of wholesale costs (determined pursuant to subsection (f)) sufficient to compensate the dispenser for the reasonable costs of dispensing such drug or device.

(4) No dispensing fee shall be approved under this section if the dispenser is a physician, unless the Board determines that there is no dispenser (other than a physician) in the community in which such physician requests to dispense covered drugs or devices.

PAYMENT FOR SPECIAL POPULATION BENEFITS

SEC. 333. (a) Payments shall be made by the Secretary for the furnishing of covered support services in accordance with part A and this section.

(b) The Board shall provide for grants to persons described in section 233 (b) for the furnishing of covered support services in such reasonable amounts as the Board determines are necessary and appropriate for the efficient furnishing of such services.

TITLE IV—FINANCING THE MATERNAL AND CHILD HEALTH PROGRAM

PART A—FUNDS FOR SUPPORT OF THE MATERNAL AND CHILD HEALTH PROGRAM

AUTHORIZATION OF APPROPRIATIONS

SEC. 401. (a) In order to assure prompt payment for the administrative and other expenses incurred during the early months of the program established by this Act, and in order to provide a contingency reserve, there is authorized to be appropriated, out of any moneys in the Treasury not otherwise appropriated, to remain available through a period of three years beginning with the date of enactment of this Act the amount of $100,000,000 for repayable advances (without interest) to the Trust Fund created by section 411.

(b) There are hereby authorized to be appropriated to the Trust Fund created by section 411 in each fiscal year such funds, in addition to funds deposited in such fund pursuant to section 412, as may be required by the Secretary to carry out the purposes of this Act.

PAYROLL AND SELF-EMPLOYMENT TAXES

SEC. 402. (a) Section 3101 of the Internal Revenue Code of 1954 (relating to social security and medicare taxes on employees) is amended by adding at the end thereof the following new subsection:

"(c) MATERNAL AND CHILD HEALTH CARE.—In addi-

tion to the taxes imposed by the preceding subsections, there is hereby imposed on the income of every individual a tax equal to 0.10 percent of the wages (as defined in section 3121 (a)) received by him with respect to employment (as defined in section 3121 (r)).".

(b) Section 3111 of such Code (relating to social security and medicare taxes on employers) is amended by adding at the end thereof the following new subsection:

"(c) MATERNAL AND CHILD HEALTH CA— —In addition to the taxes imposed by the preceding subsections, there is hereby imposed on every employer an excise tax, with respect to having individuals in his employ, equal to 0.10 percent of the wages (as defined in section 3121 (a)) paid by him with respect to employment (as defined in section 3121 (r)).".

(c) Section 3121 of such Code (containing definitions applicable to social security payroll taxes) is amended by adding at the end thereof the following new subsection:

"(r) EMPLOYMENT FOR PURPOSES OF MATERNAL AND CHILD HEALTH CARE TAX.—For the purposes of sections 3101 (c) and 3111 (c), the term 'employment' has the meaning set forth in subsection (b) of this section except that—

"(1) the exclusions contained in the following paragraphs of subsection (b) shall not be applied—

"(A) paragraph (1) (relating to foreign agricultural workers);

"(B) paragraphs (5) and (6) (relating to employment by the United States or its instrumentalities) other than paragraph (6) (C) (iii) through (v) (relating to certain minor employments);

"(C) paragraph (7) (relating to employment by States and their political subdivisions and instrumentalities) other than paragraph (7) (C) (i) through (iv) (relating to certain minor employments by the District of Columbia);

"(D) paragraph (8) (relating to employment by charitable and similar organizations);

"(E) paragraph (9) (relating to employment covered by the railroad retirement system); and

"(F) paragraph (17) (relating to employment by subversive organizations); and

"(2) subsection (m) of this section (including services by members of the uniformed services in the term 'employment') shall not be applied.".

(d) Section 1401 of such Code (imposing social security and medicare taxes on self-employed individuals) is amended by adding at the end thereof the following new subsection:

"(c) MATERNAL AND CHILD HEALTH CARE.—In addition to the taxes imposed by the preceding subsections,

there shall be imposed for each taxable year, on the self-employment income of every individual, a tax equal to 0.10 percent of the amount of the self-employment income for such taxable year.".

TECHNICAL AND CONFORMING AMENDMENTS

SEC. 403. Section 218 of the Social Security Act (42 U.S.C. 418) (relating to agreements for the coverage of services performed in the employ of States and their political subdivisions and instrumentalities) is amended—

(1) by inserting in subsection (e) (1) (A) "subsections (a) and (b) of" immediately before "sections 3101 and 3111";

(2) by inserting in subsection (e) (2) (B) "subsections (a) and (b) of" immediately before "section 3111"; and

(3) by adding at the end of subsection (e) the following new paragraph:

"(3) Notwithstanding the provisions of any agreement entered into under this section, no State shall be under any obligation to pay to the Secretary of the Treasury, with respect to service covered under the agreement and performed on or after the effective date of section 402 (d) of the Maternal and Child Health Care Act, amounts equivalent to the taxes which would be imposed by sections 3101 (c) and 3111 (c) of the Internal Revenue Code of 1954 if such serv-

ice constituted employment as defined in section 3121 (b) or section 3121 (r) of such Code."

PART B—MATERNAL AND CHILD HEALTH TRUST FUND

CREATION OF THE TRUST FUND

SEC. 411. (a) There is hereby created on the books of the Treasury of the United States a trust fund to be known as the Maternal and Child Health Trust Fund (hereinafter in this part referred to as the "Trust Fund").

(b) The Trust Fund shall consist of such gifts and bequests as may be made as provided in section 412 (c), and such amounts as may be appropriated to or deposited in such fund as provided in this part.

FUNDING OF TRUST FUND

SEC. 412. (a) There are hereby appropriated to the Trust Fund for the fiscal year ending September 30, 1976, and for each fiscal year thereafter, out of any moneys in the Treasury not otherwise appropriated, amounts equivalent to 100 per centum of—

(1) the taxes imposed by section 3101 (c) and 3111 (c) of the Internal Revenue Code of 1954 with respect to wages reported to the Secretary of the Treasury or his delegate pursuant to subtitle F of such Code on and after the effective date of section 402 (a) of the Maternal and Child Health Care Act, as determined by the Secretary of the Treasury by applying the applicable

rates of tax under such sections to such wages, which wages shall be certified by the Secretary of Health, Education, and Welfare in accordance with such reports; and

(2) the taxes imposed by section 1401 (c) of the Internal Revenue Code of 1954 with respect to self-employment income reported to the Secretary of the Treasury or his delegate on tax returns under subtitle F of such Code on and after the effective date of section 402 (d) of the Maternal and Child Health Care Act, as determined by the Secretary of the Treasury by applying the applicable rate of tax under such section to such self-employment income, which self-employment income shall be certified by the Secretary of Health, Education, and Welfare on the basis of records of self-employment established and maintained by the Secretary of Health, Education, and Welfare in accordance with such returns.

(b) The amounts appropriated by subsection (a) shall be transferred from time to time from the general fund in the Treasury to the Trust Fund, such amounts to be determined on the basis of estimates by the Secretary of the Treasury of the taxes, specified in subsection (a), paid to or deposited into the Treasury; and proper adjustments shall be made in amounts subsequently transferred to the extent

prior estimates were in excess of or were less than the taxes specified in such subsection.

(c) The Managing Trustee of the Trust Fund is authorized to accept on behalf of the United States, and deposit into the Trust Fund, money, gifts, and bequests made unconditionally to the Trust Fund or to the Department of Health, Education, and Welfare, or any part or officer thereof, for the benefit of such Fund or any activity financed through such Fund.

MANAGEMENT OF TRUST FUND

SEC. 413. (a) With respect to the Trust Fund, there is hereby created a body to be known as the Board of Trustees of the Trust Fund (hereinafter in this part referred to as the "Board of Trustees") composed of the Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health, Education, and Welfare, all ex officio.

(b) The Secretary of the Treasury shall be the Managing Trustee of the Board of Trustees (in this part being referred to as the "Managing Trustee"). The Commissioner of the Social Security shall serve as the Secretary of the Board of Trustees.

(c) The Board of Trustees shall meet not less frequently than once each calendar year.

(d) It shall be the duty of the Board of Trustees to—

(1) hold the Trust Fund;

(2) submit to the Congress not later than the first day of April of each year a report, to be printed as a House document of the session of the Congress to which the report is made, on the operation and status of the Trust Fund during the preceding fiscal year and on its expected operation and status during the current fiscal year and the next two fiscal years, which report shall include—

(A) a statement of the assets of, and the disbursements made from, the Trust Fund during the preceding fiscal year;

(B) an estimate of the expected income to, and disbursements to be made from, the Trust Fund during the current fiscal year and each of the next two fiscal years; and

(C) a statement of the actuarial status of the Trust Fund; and

(3) report immediately to the Congress whenever the Board of Trustees is of the opinion that the amount of the Trust Fund is unduly small; and

(4) review the general policies followed in managing the Trust Fund, and recommend changes in such policies, including necessary changes in the provisions of law which govern the way in which the Trust Fund is to be managed.

INVESTMENT OF FUNDS FOR THE TRUST FUND

SEC. 414. (a) It shall be the duty of the Managing Trustee to invest such portion of the Trust Fund as is not, in his judgment, required to meet current withdrawals.

(b) (1) Such investments may be made only in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States.

(2) For such purpose such obligations may be acquired on original issue at the issue price, or by purchase of outstanding obligations at the market price.

(c) (1) The purposes for which obligations of the United States may be issued under the Second Liberty Bond Act are hereby extended to authorize the issuance at par of public-debt obligations for purchase by the Trust Fund.

(2) Such obligations issued for purchase by the Trust Fund shall have maturities fixed with due regard for the needs of the Trust Fund and shall bear interest at a rate equal to the average market yield (computed by the Managing Trustee on the basis of market quotations as of the end of the calendar month next preceding the date of such issue) on all marketable interest-bearing obligations of the United States then forming a part of the public debt which are not due or callable until after the expiration of four years from the end of such calendar month; except that where such

average market yield is not a multiple of one-eighth of 1 per centum, the rate of interest on such obligations shall be the multiple of one-eighth of 1 per centum nearest such market yield.

(d) The Managing Trustee may purchase other interest-bearing obligations of the United States or obligations guaranteed as to both principal and interest by the United States, on original issue or at the market price, only where he determines that the purchase of such other obligations is in the public interest.

(e) Any obligations acquired by the Trust Fund (except public-debt obligations issued exclusively to the Trust Fund) may be sold by the Managing Trustee at the market price, and such public-debt obligations may be redeemed at par plus accrued interest.

(f) The interest on, and the proceeds from the sale or redemption of, any obligations held in the Trust Fund shall be credited to and form a part of the Trust Fund.

ADJUSTMENT OF TRUST FUND FOR OVERPAYMENTS AND UNDERPAYMENTS

SEC. 415. (a) (1) The Managing Trustee shall pay from time to time from the Trust Fund into the Treasury the amount estimated by him as taxes imposed under section 3101 (c) of the Internal Revenue Code of 1954 which are subject to refund under section 6413 (c) of such Code with

respect to wages paid on or after January 1 of the year following the date of enactment of this Act.

(2) Such taxes shall be determined on the basis of the records of wages established and maintained by the Secretary in accordance with the wages reported to the Secretary of the Treasury or his delegate pursuant to subtitle F of the Internal Revenue Code of 1954, and the Secretary shall furnish the Managing Trustee such information as may be required by the Managing Trustee for such purpose.

(3) The payments by the Managing Trustee shall be covered into the Treasury as repayments to the account for refunding internal revenue collections.

(b) Repayments made under subsection (a) shall not be available for expenditures but shall be carried to the surplus fund of the Treasury. If it subsequently appears that the estimates under such paragraph in any particular period were too high or too low, appropriate adjustments shall be made by the Managing Trustee in future payments.

PAYMENT OF SERVICES AND ADMINISTRATIVE EXPENSES

SEC. 416. The Managing Trustee shall pay from time to time from the Trust Fund such amounts as the Secretary certifies are necessary to make the payments provided for by title III of this Act and to make payments for administrative and research expenses incurred under this Act.

TITLE V—PENALTIES, EFFECTIVE DATES, AND TECHNICAL AMENDMENTS

PENALTIES

SEC. 501. (a) Whoever—

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact—

(A) in any request for payment under this Act,

(B) for use in determining eligibility for any benefit under this Act,

(C) for use in determining the qualifications of an institution, under section 202, to have payments made under this Act for such institution's furnishing of services, or

(2) knowingly and with fraudulent intent conceals or fails to disclose a material fact—

(A) in any request for payment under this Act,

(B) for use in determining eligibility for any benefit under this Act,

(C) for use in determining the qualifications of an institution under section 202, in order to

have payments made under this Act for such institution's furnishing of services; or

(3) having made application to, and received, any such benefit or payment for the use and benefit of another, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

shall be fined not more than $10,000 or imprisoned for not more than one year, or both.

(b) Whoever furnishes or dispenses a covered service to an individual for which payment may be made under this Act and who solicits, offers, or receives any—

(1) kickback or bribe in connection with the furnishing or dispensing of such service or the making or receipt of such payment, or

(2) rebate of any fee or charge for referring any such individual to another person for the furnishing or dispensing of such service,

shall be fined not more than $10,000 or imprisoned for not more than one year, or both.

EFFECTIVE DATES

SEC. 502. (a) Except as provided in subsections (b), (c), (d), and (e), the provisions of this Act shall take effect on the date of enactment of this Act.

(b) Sections 402(a), 402(b), 402(d), and 412(a) (relating to collection of maternal and child health care taxes) shall take effect on January 1 of the year following the date of enactment of this Act.

(c) Part B of title II (relating to children's benefits) shall take effect on the following dates for children of the following ages on those dates—

(1) two years after the date of enactment of this Act for children below the age of three years;

(2) four years after the date of enactment of this Act for children below the age of seven years;

(3) five years after the date of enactment of this Act for children below the age of thirteen years; and

(4) six years after the date of enactment of this Act for all children eligible under this Act.

(d) Part C of title II (relating to maternity benefits) shall take effect two years after the date of enactment of this Act.

(e) Part D of title II (relating to special population benefits) shall take effect on the effective date, specified in subsection (c) or (d) of this section, for the furnishing of covered services to which covered support services under such part are related.

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CONFORMING AMENDMENTS

SEC. 503. (a) Title V of the Social Security Act is amended by adding at the end thereof the following new section:

"PAYMENTS FOR SERVICES UNDER MATERNAL AND CHILD HEALTH CARE ACT

"SEC. 517. No payment may be made under this title for the furnishing of services which would be eligible for payment as a covered service under the Maternal and Child Health Care Act.".

(b) Section 1862 of the Social Security Act (42 U.S.C. 1395y) is amended by adding immediately after subsection (d) the following new subsection:

"(e) No payment may be made under this title for the furnishing of services which would be eligible for payment as a covered service under the Maternal and Child Health Care Act.".

(c) Title XIX of the Social Security Act is amended by adding at the end thereof the following new section:

"PAYMENTS FOR SERVICES UNDER THE MATERNAL AND CHILD HEALTH CARE ACT

"SEC. 1911. No payment may be made under this title for the furnishing of services which would be eligible for payment as a covered service under the Maternal and Child Health Care Act.".

Mr. SCHEUER. Our first witness is Dr. Abraham Bergman, director of outpatient services, Children's Orthopedic Hospital and Medical Center, Seattle, Wash.

Dr. Bergman, we are looking forward to hearing from you.

STATEMENTS OF ABRAHAM BERGMAN, M.D., DIRECTOR OF OUTPATIENT SERVICES, CHILDREN'S ORTHOPEDIC HOSPITAL AND MEDICAL CENTER, AND PROFESSOR OF PEDIATRICS AND HEALTH SERVICES, UNIVERSITY OF WASHINGTON, SEATTLE; SAUL J. ROBINSON, M.D., PRESIDENT, AMERICAN ACADEMY OF PEDIATRICS; PHILIP R. LEE, M.D., PROFESSOR OF SOCIAL MEDICINE, DIRECTOR, HEALTH POLICY PROGRAM, SCHOOL OF MEDICINE, UNIVERSITY OF CALIFORNIA, SAN FRANCISCO, ACCOMPANIED BY PETER BUDETTI, M.D., J.D., ADJUNCT ASSISTANT PROFESSOR OF HEALTH POLICY, UNIVERSITY OF CALIFORNIA, SAN FRANCISCO; AND DELMER J. PASCO, M.D., CLINICAL PROFESSOR, DEPARTMENT OF PEDIATRICS, SAN FRANCISCO GENERAL HOSPITAL

Dr. BERGMAN. Thank you, Mr. Chairman.

First of all, in your opening statement you just took away the main points of my testimony. I am very glad that you said it instead of me about the relationship between health and medical care.

If it is OK with you, I would just like to talk informally and submit a statement for the record [see p. 85].

Mr. SCHEUER. I would very much like for you to do that. Speak your piece and address yourself to the principle underlying this legislation, if you would. If we are on the right track, tell us so. If we are on the wrong track, help us get back to the right track.

Dr. BERGMAN. First of all, I wholeheartedly support the principles of the legislation. I very much believe that special legislation is needed to cover the health care costs for mothers and children. I might have another approach, which I will talk about later in the testimony. I very much support the principles of H.R. 1702 and commend you very much, Mr. Chairman, for being one of the few leaders in Congress who is talking about child headth.

I am terribly concerned that in the debate about national health insurance this aspect is lost. Those of us who work with children or in child health are very, very grateful for your efforts.

I would like to make some general comments on the debate about national health insurance. The best thing we could do is to reduce the expectations of the American people and stop some of the sloganeering.

Most people you ask on the street about what is the most important health issue in the United States will tell you national health insurance. The public is going to have to learn that it doesn't make much difference what type of national health insurance scheme is passed by Congress because it is not going to significantly improve the health of the American people.

We doctors primarily have been responsible for overselling the benefits of medical care to the people. We have a huge public relations industry.

Mr. SCHEUER. You haven't oversold the benefits of health.

Dr. BERGMAN. Of medical care.

Mr. SCHEUER. Of sickness care.

Dr. BERGMAN. Yes. OK.

Mr. SCHEUER. I suppose it is probably true that up until about 1900, until the year 1900 in all human history before that, when a doctor encountered a patient there was probably a 50–50 chance that more harm than good came out of the encounter.

Dr. BERGMAN. I don't want to put down my career and my work.

Mr. SCHEUER. Well, 77 years have passed since 1900. Today we can admit that the odds are somewhat better than that.

Dr. BERGMAN. I wish the leaders of the United Auto Workers, would sit down and talk rationally about what it is they really want instead of shouting about we need a comprehensive national health care insurance bill. Anyone who reads American political history knows there is no way that the Kennedy-Corman bill is going to be passed this year, next year or the next 10 years. That isn't the way things go in the United States.

There are certainly good features of that legislation, but as you said, if we are already at 9 percent of our gross national product in spending for health care, I don't think the American people are ready to spend 12 percent of the gross national product. We "do-gooders" can no longer claim that it is the fault of the Vietnam war. We are now calling for expenditures among programs of equal social worth. We are competing against education, cleaning up the environment, jobs, et cetera. We can't say that health care is more important than housing, for example.

I think we have almost reached the financial limit. We just can't be dumping more money. That is why I appreciated your comments about looking at some alternative approaches. The people who are concentrating their talk on medical insurance and funding, I don't think they really perceive what is going on.

Let's take for example, the effects of water fluoridation on dental health. When I came to Seattle 15 years ago—I deal mostly with poor children—and I got so I wasn't even looking in the mouths of kids because they were so horrible. I knew that I couldn't get them dental care. We fluoridated our water 7 years ago after a horrendous political fight and three times at the ballot. Now that the water is fluoridated in Seattle it is just amazing the difference that we see in these children.

Project Head Start showed that you could pour millions and millions of dollars into dental care for kids and it would be fine for the year that you are treating them. Then 2 years later when they are out of the program, they are back to where they were. Somehow we have to take the bull by the horns and wrestle with the antifluoridation kooks, who are quite a breed. If we are serious, however, about improving oral health care, that is sort of the approach we have to use.

Mr. SCHEUER. You have a story about an inebriated gentleman here in your written testimony.

Dr. BERGMAN. Can I tell that?

Mr. SCHEUER. I wish you would.

Dr. BERGMAN. This is courtesy of Leon White of Boston who wrote this in the New England Journal of Medicine. I love this story and I keep quoting it in everything that I write.

We should all like to believe that if we could just make the health-care system more efficient and effective we shall all be healthier, infant mortality will drop, and life expectancy will increase. The situation reminds me of the old story of the drunk who lost his last quarter. The drunk was searching around near a lamp post when a passerby asked him what he was doing. "Looking for a quarter I lost," replied the drunk. "Where did you lose it," asked the passerby. "Further down the road," said the drunk. "Then why are you looking here," asked the passerby. "Because the light is better," replied the drunk.

There is no doubt that the light shines brightest around the health-care system, but is better health to be found there? Maybe we should begin to look elsewhere if we are really interested in discovering ways to improve health.

I would say that this preventive concept has to be appreciated; I personally resent paying the same health insurance premium as an overweight, alcoholic smoker who doesn't buckle his seatbelt. Cheaper insurance premiums are one of the best forms of health education.

By the way, I hate the term "health maintenance organization." It is a Madison Avenue word. A good guy in Minneapolis coined it. People somehow equate HMO's with prepaid group practice. These organizations for the most part only pay lipservice to prevention.

We have an excellent prepaid group program up in Seattle; one of the best in the country. I tried to interest them in lowering their premiums for nonsmokers, for people who wear seatbelts, people who stay within certain weight limits, and they are not interested.

Mr. SCHEUER. Why is that?

Dr. BERGMAN. Because the light is better elsewhere.

Mr. SCHEUER. Insurance companies will give a lower rate to a person with so many miles without a dented fender. Why shouldn't the health insurance industry provide some kind of an incentive and some kind of an award for those who can prove that they can organize their lives to provide good health outputs without sickness care, without expensive sickness care.

Dr. BERGMAN. A few life insurance companies do this, particularly those run by Mormons in Utah. They have offered lower premiums for nonsmokers.

Getting back to what you said earlier, as soon as we put the responsibility for health care on the public rather than the doctor or the hospital, the better. We must reduce public expectation and say we are going to do less.

The politicians who are winning these days are the ones who are starting to undersell rather than oversell. The American people are not fools. The old business of telling people they are going to get something is over and we have to level with them about what the deal is.

These then are my general comments about national health insurance today. I hate the slogan: "Health care is a right." It is something that is said with great emphasis and self-righteousness. What the heall does it mean? Does someone out in a rural area have the same right as someone living next door in a metropolitan area? I don't know. It is different. It has always been tough to be poor.

Infant mortality, by the way, as you well know, has much more to do with poverty than it has to do with medical care. In countries like Holland or Denmark and places like that that have a low infant mortality rate, they don't have big infant-intensive care units. They also don't have the pockets of poverty that we do.

I want to make a case for incrementalism. This is the term that Wilbur Cohen uses. He has by far been the most successful HEW Secretary. I admire him enormously because he combines idealism with pragmatism.

Mr. SCHEUER. While you are that note, I can state parenthetically that Wilbur Cohen played a major role in putting the intellectual concepts of this bill together. He and Dr. Phil Lee were among the really early braintrusters.

Dr. BERGMAN. The issue here, as you put forth in this legislation, is a step at a time. I abhor the kamikazes who say let's have everything or nothing. They say the incremental approach in this bill is wrong because it will hold back the development of a comprehensive insurance program. I think that is nonsense and sacrificing people who need care now.

I like your approach on substantive as well as political grounds. The American people are willing to pay for the elderly. I think we need to shore up medicare. Medicare has been extremely successful and it needs to be shored up. The danger to medicare is inflation. It has been a successful program basically. The next step is mothers and kids and I think the public is ready for that. I don't think the American public is ready to pay for every cut finger or every broken leg or every headache. I think it is eminently feasible and they will accept the fact of helping pregnant mothers and children. This approach can really go. We have to help you. You are the guy that introduced the bill. It is our job to talk to some of the labor union leaders, people like that, and get a coalition together and help you.

Mr. SCHEUER. Why is it that nothing like that has happened so far? The American public is keen on improved health care, especially on a more cost-effective basis.

You would think they would be beating the bushes for this kind of an approach. Why do we feel so little support in Congress from the boondocks, from the people, for any kind of a national health care system? The labor unions are supportive, but in terms of constituent mail, in terms of what I hear when I have a town hearing in my district, they seldom mention health. The elderly people are unhappy when medicare rates go up.

Dr. BERGMAN. That is accurate. I think the reason is that 85 percent or 90 percent of the American people are getting excellent health care now. They don't feel the need. They are satisfied. It is fashionable in some circles to do a lot of doctor baiting and say, they are all evil, everyone is bad, but most people are really satisfied.

Mr. SCHEUER. Do you really think that 90 percent of the American people are getting excellent health care?

Dr. BERGMAN. I really do. There are some serious gaps, however, a big gap is the elderly in nursing homes. This is a big gap. The other gap is in mothers and children. Basically I think the people are really getting fine, really fine care. The outcry for medicare came from people going broke from medical care costs.

Mr. SCHEUER. You mean from catastrophic and serious degenerative disease?

Dr. BERGMAN. That is right. This comes to what I think the American people really want, what I personally believe that no family should have to go broke because of medical care costs. This is different

than saying that the taxpayers should pay for every single medical care visit. There is a great different. The role of the Government in this country should be to fill in the chinks, that backstop, to provide major medical coverage, but not try and run out and use taxpayer funds to do everything.

Mr. SCHEUER. In other words, for the middle-class, middle-aged Americans, which is the main group—except for children—that we have not covered in our public programs, what you would advocate is some kind of a catastrophic program? I don't want to put words in your mouth, but a catastrophic insurance program with a rather high threshold?

Dr. BERGMAN. Yes. In fact, that is what I feel should happen throughout. I would like to describe the bill that Senator Magnuson introduced in 1971 called The Children's Catastrophic Health Care Act, which was an interesting concept. What the bill really said was that catastrophe is defined as when the costs of medical care get too high, above a certain threshold. It is a percentage of the family's income and for some families they can't afford any medical care. The Government should provide all of it.

Mr. SCHEUER. Well, we have some aspects of that program in medicaid.

Dr. BERGMAN. We have it. As you well know, it is a marginal program that varies from State to State. It certainly is helpful. I think that medicaid has been knocked around, but it helps a lot of people get medical care. I think we should say some good things about it too.

Mr. SCHEUER. As a matter of fact, despite the fact that medicaid is often maligned—we all hear of overutilization, and of the ping-ponging of patients, and the provider ripoffs and whatnot—to give the devil his due—a lot of good health services are flowing out of medicaid, even in the so-called mills, in slum areas where we simply cannot get the private practitioner to serve. You can lambast the medicaid mills all you want, and I have been at the head of the line that is doing that, but I think it would be unfair not to recognize that with all that has been said and done, an awful lot of poor Americans are getting good health care out of the medicaid program. We know there are things wrong with the reimbursement system. We have documented a number of cases in medicaid mills where doctors are making $150,000 to $300,000 a year. In some cases, though, when you analyze what has happened, they have done nothing illegal. I don't suppose there is very much counseling or very much preventive health care, but as far as sickness care is concerned, they are churning out an awful lot of sickness care that simply wouldn't be provided absent the medicaid program.

Dr. BERGMAN. I totally agree with you. On a slow news day when a television station or a newspaper wants to create some stories, they go out to a poor district and you find some doctor or hospital that is making a lot of dough or something and you do not stop to look at what benefits are being provided. In my State, for instance, medicaid still provides for a lot of dental care. It really does some neat things in providing for dental care. There is very generous pharmacy coverage under medicaid. What I would like to say is that we should try and build on some of our successful health programs, too. Medicaid may

not be a successful program. To me one of the most successful is the crippled children's program.

Mr. SCHEUER. I agree that it is a successful program, but I would guess that you would agree that it is a successful program with flaws. We have to exercise these out. We should use a surgeon's scapel and not a mallet. We don't have to kill the creature, we can perform a sophisticated operation.

Dr. BERGMAN. We don't have to reinvent the wheel every time. The most successful or one of the most successful child health programs that gets the least amount of publicity, probably because it is successful and has no scandal, has been the crippled children's program. It has been in existence since 1935. As far as I am concerned, this is an outstanding Government health program which insures that children get quality medical care and they have quality assurance in the real sense and not in the fake sense of PSRO's.

The Magnuson bill in 1971 built on the crippled children's program by expanding it and saying it works well in the States, let's allow them to provide coverage for more children. It basically is a catastropic program except that all children are allowed diagnostic care free of charge regardless of income.

A major difference between that approach and the approach in your bill is payment out of general tax revenues versus social security. I am not competent to judge which is better. All I know is what I ear people talking about. They are waking up to social security as far as action within the last year by Congress. People used to think it isn't going to cost me any more if it is social security. I think now people realize that isn't so.

Mr. SCHEUER. We are reaching the upper limits of our capability to provide services, we are down to the question of picking and choosing between equally valid claims on the public treasury, I think we have got to quantify what things cost. I think people have to understand that there are no free lunches. They are finding that out when they pay their taxes to Uncle Sam at the end of the year.

Dr. BERGMAN. We can still be good liberals and say that.

Mr. SCHEUER. Yes. You have to make some kind of value judgments and some kind of cost benefit weighing when you support programs and support politicians who support programs. I think one way of sensitizing people to the fact that all of these programs do cost money is to make the costs a ticket item so they know what they are paying.

Dr. BERGMAN. Let me summarize the features of the Magnuson bill. It was designed to expand the crippled children's programs to provide more coverage, that the Federal Government provide coverage at a point according to the family's income, that when medical care costs exceeded a certain level, say, for instance, exceeded $2,000 for a family with, say a $20,000 income, then the Government would step in. At a higher income it would be a higher ceiling. The third feature of the bill was to expand the current maternal and infant health care program to provide universal coverage for pregnant women. That feature you have in your bill and I think it is exceedingly important.

Mr. SCHEUER. How do we provide incentives for people to take care of their own health outcomes and at the same time disincentives for them to overstress and overburden the system with trivial claims that are unnecessary?

Dr. BERGMAN. That is the topic of an article that I have appended to my testimony—it is called Health Education, but health education using the techniques of the masters, the advertising industry. Here in the bay area it has been shown that through use of television advertising it is possible to promote good health habits. The public owns the airways. We are spending all this money for health and I would like to see the effect of countercommercials. I would like to see us use the same techniques in health promotion. As you know, the biggest loss to the tobacco advertising was when it came off of television. The reason was that up to that time the TV stations were obliged to show smoking countercommercials and they were really scared when that happened.

The effect now has been that they don't have to budget for television advertising and we don't see countercommercials any more. The Federal Trade Commission should have legislation to say that a certain percentage of television time be devoted to health education, but that it be not the preaching kind of health education but something that we are really serious about.

[Testimony resumes on p. 113.]

[Dr. Bergman's prepared statement and attachments follow:]

MOTHERS AND CHILDREN NEED HEALTH INSURANCE COVERAGE NOW

Testimony of Abraham B. Bergman, M.D.
on H.R. 1702 ("Maternal and Child Health Care Act")
before the Subcommittee on Health and the
Environment of the Committee on Interstate and
Foreign Commerce, House of Representatives.
The Hon. James H. Scheuer, (D, N.Y.), presiding
San Francisco, California
January 4th, 1978

Dr. Bergman is Director of Outpatient Services, Children's Orthopedic Hospital and Medical Center, and Professor of Pediatrics and Health Services at the University of Washington, Seattle.

Mr. Chairman:

I am here to support the principles of H.R. 1702, the Maternal and Child Health Care Act, and to applaud your personal efforts on behalf of improved health for mothers and children in the United States. So many platitudes are expressed by our political leaders about the value of children in our society which are quickly forgotten when it comes time to attach money to mouths. The swine flu fiasco is a perfect case in point. The steady erosion of support for the federal vaccination assistance program is directly correlated with dropping immunity levels to childhood diseases like diphtheria, pertussis, tetanus, measles, rubella and polio. Yet the moment some adults were threatened by influenza, the resources of the federal government were quickly mobilized for a crash immunization campaign.

In my testimony today I'd like to touch upon a few general issues regarding National Health Insurance (NHI) and then make some suggestions regarding health insurance for mothers and children.

MAXIMUM FEASIBLE MISUNDERSTANDING

The best thing that could happen in the debate about NHI would be to cut out the emotional sloganeering and get down to reality. Here's one big dose: the health of the American people is not going to be significantly affected one way or the other by whatever type of NHI scheme that is enacted into law. The reason is that NHI concerns itself with payment for medical care. Medical care, in turn, is not invariably related to better health. Bluntly, the benefits of medical care have been oversold. The American people are victims of, in Moynihan's term, "maximum feasible misunderstanding". Health programs are being cut because they cost too much and their benefits are not apparent. General Motors says its health insurance payments exceed those to U.S. Steel, its largest supplier. In fiscal 1960, national health expenditures totalled $25.9 billion; in 1976, the figure was $139.3 billion, over 8.6% of our gross national product. Health is now competing for dollars not only with defense, foreign aid and highways, but with programs of comparable social value such as those aimed at providing housing, education and a liveable environment.

Most politicians still have not caught on. Cut costs, they say. Thus, there are more regulations, more review bodies, more alphabet soups like HMO's, PSRO's, HSA's, producing more jobs for regulators, paper suppliers and computer operators, but none of them making people any healthier or significantly lowering costs. Medical care, Mr. Chairman, is absolutely necessary; I would be the last person to "put it down". The "religious" supporters of comprehensive

national health insurance, however, have got to get it into their heads that they will not reach Sangri-la even if all the money in the world were available to pay for medical care.

Leon White of Boston says:

> We should all like to believe that if we could just make the health-care system more efficient and effective we shall all be healthier, infant mortality will drop, and life expectance will increase. The situation reminds me of the old story of the drunk who lost his last quarter: The drunk was searching around near a lamppost when a passerby noticed him and asked what he was doing. "Looking for a quarter I lost," replied the drunk. "Where did you lose it?" asked the passerby. "Further down the road," answered the drunk. "Then why are you looking here?" asked the passerby. "Because the light's better," replied the drunk.
>
> There is no doubt that the light shines brightest around the health-care system, but is better health to be found there? Maybe we should begin to look elsewhere, if we are really interested in discovering ways to improve health.

It is these areas away from the streetlight that need further exploration. Sanity is likely to return to the American health care scene only if the public has more realistic expectations of what medicine can and cannot provide. A corollary is that better health will result only when the public takes greater responsibility, both individually and collectively, for achieving it.

HEALTH CARE JARGON

Our "new" language in this field muddies the water. "Health care" has become a commodity to be "delivered" by "vendors" to "consumers". One can pay for the services of a physician, but can health or "health care" be purchased as though it were a concrete item on a grocery shelf? Richard M. Magraw says:

> We need to bear in mind that patients are not the same thing as consumers. Patients ask for help and care (derivatively "patient" means one who suffers), whereas consumers buy and use things. Sick people may describe themselves as being "sick" or "ill" or even as being "patients", but never as "consumers". Hence, he who speaks with a "consumer" in mind is probably not speaking for patients. The term "consumer" has overtones of "buying power" and economies of scale. Patients are sick. Are consumers? If they are not, how can they "consume" the medical-care part of health services? "To consume" hardly seems the right verb for that service, in any case.

> Once launched, some of this jargon attains a momentum of usage, but other factors help it flourish. Some prefer this language because it helps make the awkward human complexities of persoanl medical care more manageably abstract -- for planning, to fit economic theory and for other purposes. Others use it to belittle (unconciously) the still rather grandiose social role of the physician. They prefer to speak of "providers and consumers" rather than "doctors and patients" or of "vendors" rather than "physicians." We have perhaps not given enough thought to elements of pretentiousness in our staked-out claims of professional expertness and responsibility, and to the effects of the residual grandeur of society's lingering image of the doctor.

Put bluntly, the emperor needs his clothes, the Wizard of Oz needs his trappings, and the physician needs his aura to achieve maximum benefit for his patient. Take away the "magic" and honesty is gained, but a measure of healing power is lost. For better or worse, the trend towards egalitarianism probably will not be reversed.

Let's return to Leon White's streetlight. He says, "the real malpractice problem in this country today is not the one described on the front pages of daily newspapers but rather the malpractice that people are performing on themselves and on each other."

SLOGANS

I hate the slogan "health care is a right!" One can sound very self-righteous saying it, particularly in emphatic terms. But what the hell does it mean? Does an individual who doesn't buckle his seat belt and flies through the windshield of his car in an accident have the right to taxpayer-funded hospital care? Does the smoker who develops lung cancer have the right to have his family supported by taxpayers after he dies at age 55? These sound like brutal questions, but I submit that true improvements in health will take place in the United States only when individuals are able to improve their "health habits".

Another misleading Madison Avenue sligan is Health Maintenance Organization (HMO). I am not in the least bit opposed to prepaid group medical practice. Let's not view it, however, as any great nirvana. Most of the programs with which I am familiar do a good job of selecting out the healthiest segment of American society to cover, and exclude persons that engendered the highest medical care costs, i.e. the very poor, the disabled, the mentally ill, etc. I've suggested to our excellent prepaid program in Seattle, Group Health Cooperative of Puget Sound, that they offer lower premiums for individuals who don't smoke, use seat belts and stay within certain weight limits. To date they've shown no interest. Likewise, third party payers like Blue Shield and Blue Cross have shown scant interest

in promoting healthier living habits among their subscribers. They see themselves solely as agents to rubber stamp physician and hospital bills.

ORAL HEALTH

Let's look at oral health. The federal government has poured millions of dollars into restorative dentistry. Project Head Start is a good example. Money was available to fix the teeth of young children. Yet after they passed the Head Start age limit, their teeth reverted to previous miserable states. My practice is almost exclusively with the children of low-income families. When I first came to Seattle fifteen years ago, I got in the habit of not even looking in the mouths of the children because I knew I had nothing to offer those with severe dental caries. Seven years ago we fluoridated our water. Now it's a whole new scene. I almost never see children with rampant caries. Despite this impressive evidence, anti-fluoridationist kooks keep the benefits of water fluoridation away from millions of children in the United States.

OK, I hope I've made my point about the necessity of getting serious about preventive medicine. There are a lot of things we can do. If you're interested, we can discuss them in the question period. At the conclusion of my testimony I will submit for the record two papers I have written recently about our lack of committment to preventive medicine.

THE CASE FOR INCREMENTALISM

As I said before, I do not in any way deprecate the importance of medical care. I merely want to sort out the differences between improving health and providing medical care. My own personal philosophy is that no one in this country should be denied needed medical care for lack of money. I also believe in tackling the most pressing problems first. No family should have to go broke in order to secure adequate medical care. The government, in my opinion, should serve as a backstop to avert financial disaster for families when their own means are either unavailable or exhausted. Translated, this means that I favor catastrophic health insurance with catastrophy defined as a proportion of a family's income. It's exceedingly important to recognize that over 85% of American citizens currently are receiving satisfactory medical care. National Health Insurance should fill in the gaps. These gaps occur in two ways. First, there are the poor or near-poor who are currently "covered" under such programs as Medicaid in a most inadequate fashion. The second group are the "medically indigent" who sustain such large medical bills that they are thrust into poverty. National Health Insurance should thus be directed toward coverage of these two important groups. I believe the American public is quite willing to pay taxes to cover the medical care costs of an elderly individual with a stroke or an infant with a severe birth defect. On the other hand, I don't feel our citizens wish to pay higher taxes to provide coverage for every cut finger, hernia operation or

broken arm. (Incidentally, when I talk of medical care costs I include dental and mental health services.)

KAMIKAZES

Wilbur Cohen is a most remarkable man. By almost any measure he's been our most successful HEW Secretary. He's responsible for drafting the country's most important health legislation, including Medicare. What I particularly admire about Wilbur is his combination of humanism and pragmatism. He has a deep understanding of American political history which is absolutely imperative when dealing with such large social issues as national health insurance. The President of the United Auto Workers notwithstanding, there is absolutely zero chance that any President will propose nor that Congress will enact a health insurance program as broad as the Kennedy-Corman bill. Incrementalism, as Wilbur Cohen calls it, is the only way we are going to get to comprehensive national health insurance -- a step at a time. The diehards who insist on Kennedy-Corman or nothing are kamikaze pilots. They'd rather crash and burn than win the game.

Despite all the griping, Medicare has been an extremely successful program. Inflation has caused severe hardship for many oldsters; benefits must keep pace with costs so that the goals of Medicare are maintained.

The next groups to be covered are pregnant mothers and children. That is why the bill you introduced, Mr. Chairman, is so important and deserves widespread support. As you have repeatedly pointed out, enactment of the Maternal and Child Health Care Act is a logical step on the way to more comprehensive health insurance coverage. Given the amount of federal funds now spent on a disjointed number of programs already covering mothers and children, the additional cost for a truly coordinated, comprehensive program would not be much greater than we already spend. I submit that the American public is also ready to support comprehensive health insurance coverage for pregnant mothers and children in 1978 where, given the costs, they are not ready for universal health insurance.

CHILDREN'S CATASTROPHIC COVERAGE

In line with the philosophy I expressed previously of meeting the most urgent needs first, I feel attention should be directed toward covering the costs of "catastrophic" illnesses or disabilities. There is hardly a family in America today that has the private means to cover the medical expenses of a child with meningomyelocele, cystic fibrosis, leukemia, cleft lip and palate, rheumatoid arthritis, or a host of other disorders. I therefore commend to your attention a bill introduced by Senator Warren Magnuson of my state into the 92nd congress, entitled "The Children's Catastrophic Health Care Act of 1971." Under that legislation, a child would be eligible for free catastrophic medical care and services whenever the cost of his treatment became prohibitively expensive. "Catastrophic" would be

defined as medical care costs exceeding a certain proportion of the family's income. For example, for a family with an annual taxable income of $15,000 or less, the program would pay all of a child's annual medical expenses which exceeded 5% of the family's income. A family earning more than $15,000 would become eligible when their child's medical fees exceeded the sum of 5% of the first $15,000 of their income and 10% of everything above $15,000. The actual dollar values are not as important as the principle of the government covering "major medical" expenses. No family would be financially ruined by the medical bills brought on by catastrophic childhood illnesses, defects or injuries.

A big advantage of Senator Magnuson's bill was that it built upon an existing successful government health program, Crippled Children's Services (CCS). Perhaps just because it has been so successful, i.e. no scandals, CCS has not received sufficient attention in discussions about NHI. The program which came into being under Title V of the Social Security Amendments in 1935 operates in all 50 states. In contrast to Medicaid which is strictly a payment mechanism, CCS insures quality medical care by insisting on an approved treatment plan. Diagnostic evaluations are available for all children with no family income restrictions. Treatment, however, is provided only when the family has inadequate resources.

Another feature of the Magnuson bill was to expand the existing Title V Maternal and Infant care program to provide maternal care to all low-income mothers and health care to all their infants during the first year of life. The M&I special project grants currently serve less than a sixth of families theoretically eligible for the program.

The Children's Catastrophic Health Care Act would then build upon an already functioning, already proven system to: first, provide comprehensive health care to all children suffering from major defects, diseases or injuries; and second, provide comprehensive maternal and infant care for all low-income mothers and their babies. A major difference between Senator Magnuson's 1971 legislation and H.R. 1702 is that the former would be funded through general revenues rather than the Social Security system. I am not competent to judge which approach is better -- I simply urge that the Committee study the approach and integrate any features you feel are useful as you mark up H.R. 1702.

In summary, the need for improved coverage for mothers and children in the United States is unquestioned. It is politically feasible to enact such legislation in 1978. I enthusiastically commend you for your efforts. Thanks for the privilege for appearing before you today.

United States of America

Congressional Record

PROCEEDINGS AND DEBATES OF THE 92d CONGRESS, FIRST SESSION

Mr. MAGNUSON. Mr. President, the health care crisis has come to command more concern within the Congress and throughout the Nation than has any other single domestic issue. Even more important, this concern has been translated into serious legislative proposals by many Members of the Congress, by the administration and by many private groups outside of Government.

As chairman of the Appropriations Subcommittee on Labor-HEW I can assure the Senate that this concern is wholly justified and that this commitment to action is absolutely imperative. More than a year ago when I opened the 1970 health appropriations hearings I warned that the Nation was fast approaching "a health crisis whose proportions defy adequate description." I continued:

This crisis extends from our medical schools to our hospitals, from our laboratories to our clinics. The dimensions of this crisis are stark. The United States today is not even among the leading nations of the world in life expectancy of men, women or infants. We are producing new doctors at a rate of fewer than 9,000 per year; we are lagging in health research; we lack adequate facilities to apply the fruits of accomplished research to the health care needs of our expanding population.

I accepted this post as Chairman of this Subcommittee because I believe that the health and welfare of our people must be an urgent concern of this Government. In my second year, as Chairman, I am even more determined and more convinced that more must be done.

And, today, Mr. President, in my third year as chairman of the subcommittee, I am still more determined and still more convinced that still more must be done. It is a vast task and I am indeed encouraged by the number of Senators who have come forward and squarely confronted this crisis. The distinguished senior Senator from Massachusetts deserves special recognition and credit for having given much impetus to this national concern by introducing his National Health Security Act in the last Congress. Also, of course, the hearings which he and the other members of the Health Subcommittee have held throughout the Nation in recent months have focused even more attention on the health crisis and have produced valuable information that will be most helpful to the entire Congress as we seek to develop a final health insurance program. As a cosponsor of Senator KENNEDY'S National Health Security Act, both last year and again this year, I truly admire his leadership in this vital area of national need.

The distinguished chairman of the Finance Committee is also deserving of special praise for having introduced last year the concept of catastrophic health insurance. I have utilized that concept in writing the bill I intend to introduce today, and I believe it is an extremely important concept which commands the closest consideration of every American who is seriously committed to resolving the health care crisis.

These and all of the other health insurance proposals offer important ideas, concepts and mechanisms which, when molded together into a final bill, will, I am sure, furnish the Nation with an effective and fiscally responsible national health insurance system. This is an objective singularly worthy of the vast amount of time, study and hard work which I know Chairman LONG and the other members of the Finance Committee will expend in writing a final Senate bill.

Mr. President, neither I nor any other Senator would advocate that Congress move rashly or recklessly in its efforts to establish a national health insurance system. That is a task which will require much deliberation, time-consuming as that may be. However, we cannot afford to ignore the particularly crucial and pressing problems posed by major childhood illnesses which continue to maim many children simply because their parents cannot afford proper medical treatment and continue to leave thousands of families destitute with nothing but unpaid medical bills to show for years of savings. Nor can we continue to ignore the fact that each year thousands of infants are born deformed or die within their first year of life simply because they are born to low-income mothers who cannot afford proper maternal care for themselves or sufficient health care for their babies.

The dimensions of these two problems are shocking. For example, birth defects alone—just one category of major, or catastrophic, childhood illnesses—currently affect 2.5 million Americans under the age of 20. So that other Senators may have a clearer view of just this one part of the overall problem presented by catastrophic childhood illnesses I ask unanimous consent to have printed in the RECORD at this point in my remarks a table listing the major birth defects and the number of children afflicted by them.

PREVALENCE OF COMMON BIRTH DEFECTS

Mental retardation of prenatal origin	1,170,000
Congenital blindness and lesser visual impairment	300,000
Congenital deafness and lesser hearing impairment	300,000
Genitourinary malformations	300,000
Muscular dystrophy	200,000
Congenital heart and other circulatory disease	200,000
Clubfoot	120,000
Cleft lip and/or cleft palate	100,000
Diabetes	80,000
Spina bifida and/or hydrocephalus	60,000
Congenital dislocation of hip	40,000
Malformations of digestive system	20,000
Speech disturbances of prenatal origin	12,000
Cystic fibrosis	10,000

In almost every major category of birth defects listed in the table there are more afflicted children than there are people in a major city. And, while low-income children are more prone to be victims of birth defects because of the insufficiency of maternal care presently available to their mothers, children from higher income families are in no way immune from these tragic defects. Clearly, then, when one adds the number of youngsters who are born in good health but later contract major illnesses or suffer serious accidents to the 2.5 million children suffering from birth defects he

finds a national problem of truly catastrophic dimensions.

And it is a problem which is financially catastrophic to individual families. The care of a child with a major defect, illness, or injury generally entails prolonged hospitalization, care by a wide array of highly trained professionals and expensive equipment. Medical bills rapidly mount into the thousands of dollars, surpassing the coverage offered by even the better private insurance plans and far outstripping all but the richest family's ability to pay. When the average family's income is well below $10,000 and when most Americans earn far less than the average, how can we expect families to pay medical bills running into the thousands of dollars and often coming year after year after never-ending year? We cannot, Mr. President, and we should not.

An equally tragic and shocking picture comes into view when we examine the plight of the infants who are born every day into low-income families. Because women from these families so often cannot afford proper maternal care during their pregnancies or adequate obstetrical care at the time of delivery, their babies far too often come into this world unhealthy as well as poor. And the same poverty which denied their mothers adequate maternal and obstetrical care continues to rob these infants of the health care that is so crucial in the first year of life. As a consequence of this national neglect, the incidence of prematurity among infants born to low-income parents is about 12 percent as compared to the national average of 8 percent. Premature infants—and particularly those born into poverty—are especially apt to be born with major health problems, to be malnourished and to die within their first year of life. While the national infant mortality rate is unacceptably high—21.8 deaths in the first year per 1,000 births—the rate for babies of low-income parents is often twice as high, or about 43 deaths per 1,000 births. As a nation founded upon the dignity of human life can we tolerate this situation where infants are maimed for life or even die for no other reason than that their mothers are unable to obtain proper medical care for themselves and their babies? We should not, Mr. President, and we cannot.

The problems posed by catastrophic childhood illnesses, by insufficient maternal care for low-income families and by inadequate health care for their infants cannot be left unresolved while we continue the long, arduous task of devising a workable legislative solution to the entire health crisis/crisis. We must act now to solve these problems.

Mr. President, we can act now for we need not, construct new administrative structures or engage in the extensive deliberations that are necessary whenever we set out to build a new program from the ground up. Instead, we can begin immediately to resolve these problems by building as the bill I am about to introduce would do, upon two concrete programs that have long since proved their effectiveness. These are the crippled children's services program operating in all 50 States, and the maternal and infant care program, located in 33 States. Both are authorized under the present title V of the Social Security Act and are administered by the Department of HEW.

I am hopeful, then, that Senators will carefully examine the approach offered by this legislation, suggest ways in which it can be improved and give serious consideration to the possibility of implementing this approach, perhaps as part of the social security bill now being considered by the Finance Committee, so that we begin as soon as possible to deal with the tragic problems I have outlined above.

Mr. President, I now introduce for appropriate reference the Children's Catastrophic Health Care Act of 1971 which would become the new title V of the Social Security Act, replacing the current title V entitled "Maternal and Child Health and Crippled Children's Services." As I have indicated it would substantially expand both the crippled children's program and the maternal and infant care program authorized under the current title V. In addition, it would continue a variety of other title V programs of significant importance in our effort to make adequate health care available to all Americans. Under my bill, these programs would be funded through the normal appropriations process as is now done—not through payroll deductions or taxes. States would continue to share the cost of their expanded crippled children's programs—to be renamed the children's catastrophic health care program—and their maternal and infant care programs. However, they would only be required to continue their funding at its fiscal 1971 level. Other costs would be paid by the Federal Government.

Mr. President, the children's catastrophic health care program authorized under my bill would expand the existing crippled children's program in three important ways. First, it would provide care and services to children in all families—not just to those who come from low-income families as is presently the case. Second, it would expand coverage to include all health care costs once they exceeded a fixed percentage of a family's income. Third, it would standardize the coverage provided.

My own State of Washington presents telling examples of the problems which hobble the crippled children's program. Today, only 4,000 Washington youngsters are being treated under the crippled children's program although the State director estimates there are at least 16,000 children in need of treatment. In other words, without new legislation of the type I am proposing, only one-fourth of the children in my State who need treatment will receive it. And the story is no more encouraging in other States.

Eligibility standards vary widely from State to State. Since not all children can be served at existing funding levels, arbitrary eligibility standards are drawn. Most States, for example, provide services for children who require orthopedic surgery or plastic surgery to correct handicaps, but only a relative few provide services for children with chronic medical problems or congenital defects.

In Washington, children are covered for treatment of cleft palate and club-foot, but they are not covered for cystic fibrosis, hydrocephalus or epilepsy. Nor are children in my State covered for kidney disease, congenital or acquired blood disorders—such as hemophilia—diabetes, cancer, eye disease or chronic brain disorder. I need hardly remind the Senate that these health problems for which children in my State are not covered are the most devastating, the most tragic, and also the most expensive to treat. Today, then, in my State, families with children suffering from one or more of these health problems cannot expect any assistance from the very program established by Congress to cover the cost of their treatment.

Nationally, mental health services for children are not covered under the crippled children's program as they would be under my bill. This is particularly important when one realizes that there are at least 1 million children in the United States today who require these crucial, but costly, services.

There are many other examples. For instance, hydrocephalus is a condition in which a grossly abnormal amount of fluid collects around the brain, creating pressure on the delicate brain tissues that leads to permanent mental retardation, loss of physical capacity, and even death. An operation can be performed to relieve this pressure and to prevent its destruction, but it is not covered under the crippled children's program. And the list goes on and on. Metabolic disorders such as rickets—which causes permanent deformities—and urinary tract disorders—which cause deterioration of the kidneys, high blood pressure and death—can be treated by special medicines and by corrective services. But, once more, the present crippled children's program does not cover the cost of such medicines or surgery.

Perhaps the most tragic example of all is presented by cystic fibrosis. Thousands of American youngsters die needlessly from this disease because we have neglected to make its costly treatment available to more than a fraction of its victims. One out of every 1,500 babies born in the United States are born with cystic fibrosis. In 1950, half the children with this disease were dead by age 3 and only 10 percent lived to the age of 10. But with new methods of care, modern treatment centers now treat cystic fibrosis victims so successfully that the median age of death in these centers is now 21. And no less than 50 percent of all children afflicted with this terrible disease survive past the age of 20 when treatment is available. But, because of inadequate funds, only a minute fraction of cystic fibrosis patients receive the care medical science has made possible. Enactment of the Children's Catastrophic Health Care Act would make this treatment available to all of these children.

In sum, the arbitrarily drawn eligibility standards that now govern crippled children's services mean financial ruin for families. But the greatest tragedy—one which I cannot overstress—is that unnumbered thousands of children are permanently crippled or doomed to an early and tragically unnecessary death

because their parents cannot afford treatment for health problems that can be cured.

The Children's Catastrophic Health Care Act would eliminate the arbitrary eligibility standards drawn by the States and would provide adequate funding to insure that all eligible children receive the treatment they require. The new national eligibility standard would be based not on kinds of disease but rather on the cost of treatment in relation to family income.

Under this legislation a child would be eligible for free catastrophic health care and services whenever the cost of his treatment became prohibitively expensive. For a family with annual taxable income of $15,000 or less, the program would pay all of a child's annual medical expenses which exceeded 5 percent of the family's income. A family earning more than $15,000 would become eligible when their child's medical fees exceeded the sum of 5 percent of the first $15,000 of their income and 10 percent of everything above $15,000.

This meant that for a family earning $8,000, the children's catastrophic health care program would pay all medical costs which, for any child in any year, exceeded $400. For a family earning $10,000 the program would pay costs in excess of $500. For a family with an income of $16,000 it would pay costs in excess of $850, and for a family with income of $20,000 the program would pay all costs in excess of $1,250. No family, therefore, would be financially ruined by the medical bills brought on by catastrophic childhood illnesses, defects or injuries.

In the program's first year, all children under the age of 7 would be covered. In succeeding years, benefits would be available to these children and all new babies, hence in the second year all children under the age of 8 would be covered, in the third year all children under the age of 9 would be covered and so on until in 1983 all children—under 18—would be covered.

The second major section in my bill and its effect on the existing title V maternal and infant care program can be described quite briefly. This bill would expand these programs, now serving only 33 States, to include all 50 States. Furthermore, it would provide maternal care to all low-income mothers and health care to all of their infants during the first year of their lives.

The maternal and infant care special project grants currently serve only 125,000 of the 750,000 mothers who need this type of assistance. For this fortunate one-sixth, the evidence demonstrates that the results of the maternal and infant care program has been a dramatic reduction in infant mortality, malnutrition and attendant diseases. Under the Children's Catastrophic Health Care Act this maternal and infant care would be available to all low-income women and their babies. In addition, all infants, regardless of their families' income status, would be eligible for free domestic services.

The Children's Catastrophic Health Care Act, then, would build upon an already functioning, already proven system to: first, provide comprehensive health care to all children suffering from major defects, diseases or injuries; and second, provide comprehensive maternal and infant care for all low-income mothers and their babies. This legislation offers a practical method for dealing almost immediately with the most urgent health care problems of our children. Furthermore, by making this care available to children as soon as they are born—and, in fact, almost from the day of conception—we would prevent the occurrence of a great many painful and expensive defects and diseases. Consequently, early enactment of this legislation would not only save many children the agony of unnecessary sickness but would also save the nation the huge sums it will have to expend for corrective care if we delay acting until comprehensive national health insurance becomes a reality.

Mr. President, in addition to the crippled children's services program and the maternal and infant care program, title V of the Social Security Act authorizes a number of other programs which, while much smaller, are an important part of the Nation's overall health effort. Under my bill most of these programs would be continued through fiscal year 1977 and strengthened with separate funding authorizations. These programs and their annual funding levels under my bill are:

Programs to promote the health of preschool and school age children—$50 million.

Family planning services—$5 million.

Projects of regional or national significance in the advancement of maternal and infant care—$10 million.

Projects of regional or national significance to the improvement of the treatment of crippling diseases—$10 million.

Training of health personnel, particularly personnel to work with children who are mentally retarded or afflicted with multiple handicaps—$20 million.

Research projects designed to advance the care and treatment of crippled children, pregnant women and infants—$10 million.

In closing, Mr. President, I wish to reiterate three important points:

First, this legislation is not an alternative to a comprehensive national health insurance system. As my cosponsorship of Senator KENNEDY's National Health Security Act evidences, I am a proponent of a truly comprehensive system. And I believe we must move toward implementation of such a system just as rapidly as we possibly can without sacrificing sound legislation for speed. Rather than being an alternative to a comprehensive program, the Children's Catastrophic Health Care Act offers an important first step toward the development of a comprehensive program.

Second, this bill avoids duplication or the creation of new paper-strangled bureaucracies by building upon an existing and effective program.

Third, this bill is not offered as a finished legislative product. Instead, it is offered as a working paper. Hopefully, it will be considered by other Senators and particularly by those who are now studying the new social security bill and who will eventually be designing a final Senate health insurance bill. And, hopefully, it offers an approach which, after appropriate committee refinement, will receive the Senate's approval.

Mr. President, I ask unanimous consent that the entire text of my bill, The Children's Catastrophic Health Act of 1971, be printed in the RECORD at this point.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

A bill "The Children's Catastrophic Health Care Act of 1971"

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Children's Catastrophic Health Care Act of 1971".

AMENDMENT

Title V of the Social Security Act is amended to read as follows:

TITLE V

STATEMENT OF FINDINGS AND PURPOSES

SEC. 501. The Congress finds that—

(1) Safeguarding the health of all the nation's children is not only humane, prudent and compassionate but also mandatory for the nation's best interests;

(2) The expense of providing adequate health care to children suffering from major illnesses often comprises a financial catastrophe for families and too often stands as a barrier between children and their well-being;

(3) The failure to provide children with adequate health care solely because of their families' financial limitations is so inimical to the national interest as to comprise a national catastrophe;

(4) The health or ill-health of children in their later years is directly related to the maternal care or lack of maternal care which their mothers receive and to the care which they receive during the first year of their life;

(5) Of the 750,000 infants born each year to low-income families, 600,000 are borne by women who do not receive adequate maternal care;

(6) The mothers of half of all such infants receive no maternal care whatsoever; and

(7) The inadequacy or total lack of maternal care available to women from low-income families leads to a disproportionate incidence of prematurity, congenital defects, still births and infant deaths among infants born to low-income families.

Therefore, it is the purpose of this Act to ensure adequate health care to children suffering from major illnesses, to ensure adequate care to all infants born to low-income families, and to ensure adequate maternal care to all women in low-income families.

DEFINITIONS

SEC. 502. For the purposes of this Act—

(1) "The Secretary" shall mean the Secretary of Health, Education, and Welfare;

(2) "Low-Income Family" shall mean any family so defined by the Office of Economic Opportunity Income Poverty Guidelines; and

(3) "Infant" shall mean a child in his first year of life.

CHILDREN'S CATASTROPHIC HEALTH CARE PROGRAM

SEC. 503 (a) For the purposes of this section there is authorized to be appropriated for the fiscal year ending June 30, 1972 and for each succeeding year thereafter such funds as the Congress shall deem necessary.

(b) Care and services included under this section shall include the diagnosis of illness, the provision of medical, surgical and corrective care, the provision of aftercare, the

provision of such facilities as are necessary for providing such care and the identification of children requiring such care provided that—

(1) in the case of a child whose family's annual taxable income is $13,000 or less, the combined cost determined pursuant to Sec. 506 (a)(3) of all such care and services provided in one twelve month period shall exceed 5 per centum of the family's annual taxable income; or

(2) in the case of a child whose family's annual taxable income is greater than $13,000 the combined cost as determined pursuant to Sec. 504 (a)(3), of all such care and services provided in one 12 month period shall exceed the sum of 5 per centum of the first $13,000 and 10 per centum of all income greater than $13,000

(c) Care and services authorized under this section shall be initiated

(1) in calendar year 1971 for only those children who will not have reached the age of seven years as of December 31, 1971;

(2) for calendar year 1972 and in succeeding years for (A) all children eligible under (1) until such children reach age 18; and (B) all children born in such years until such children reach age 18.

(d) The Secretary shall pay to each State that has a State plan approved under Sec. 506 such sums as it requires to pay that part of the cost of care and services provided a child under this section which—

(1) in the case of a child whose family's annual taxable income is $13,000 or less, is greater than 5 per centum of the family's annual taxable income; or

(2) in the case of a child whose family's annual taxable income is greater than $13,000, is greater than the sum of 5 per centum of the first $13,000 of such income and 10 per centum of all such income greater than $13,000

(e) Subsection (d) notwithstanding, the Secretary shall pay to each State that has a State plan approved under Sec. 506 such sums as it requires to carry out the provision of Sec. 506 (a)(9).

MATERNAL AND INFANT HEALTH CARE

Sec. 504 (a) For the purposes of this section there is authorized to be appropriated for the fiscal year ending June 30, 1972 and for each succeeding year such sums as the Congress shall deem necessary.

(b) The Secretary shall pay to each State having a State plan approved under Sec. 505 such sums as it requires to provide comprehensive maternal care to all women of low-income families, and to provide comprehensive health care to all infants born to low-income families, and to provide diagnostic services for all infants of all families.

APPROVAL OF STATE PLANS

Sec. 505 (a) To be entitled to payments under Sec. 503 and Sec. 504 a State must have a State plan which—

(1) provides for carrying out the purposes of Sec. 503 and Sec. 504

(2) provides that the State shall pay no less in any fiscal year for care and services authorized under Sec. 503 and Sec. 504 of this Title than it paid in the fiscal year which ended June 30, 1971 for care and services authorized under Sec. 503 and sec. 504 of Title V of the Social Security Act as in effect prior to the enactment of this Title.

(3) provides that the cost of care and services provided under this Act shall be reasonable as determined in accordance with standards established by the Secretary;

(4) provides for the administration of the plan by the State health agency or the supervision of the administration of the plan by the State health agency of the administration (or supervision thereof) of the plan by another State agency approved by the Secretary;

(5) provides such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods) as are necessary for the proper and efficient operation of the plan;

(6) provides for the training and effective use of paid subprofessional or paraprofessional staff, with particular emphasis on the full-time or part-time employment of persons of low-income, as community service aides, in the administration of the plan and for the use of nonpaid or partially paid volunteers in providing services and in assisting any advisory committee established by the State agency;

(7) provides that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as he may from time to time find necessary to assure the correctness and verification of such reports;

(8) provides for cooperation with medical, health, nursing, educational and welfare groups and organizations and, with respect to the portion of the plan relating to care and services authorized under Sec. 503, with any agency in such State charged with administering State laws providing for vocational rehabilitation of physically or mentally handicapped children;

(9) provides, with respect to the portion of the plan relating to care and services authorized under Sec. 503, for early identification of children in need of such care and services through provision of such periodic screening and diagnostic services as may be provided in regulations established by the Secretary;

(10) provides a program (carried out directly or through grants and contracts) of projects of the type described [illegible] which offer reasonable assurance particularly in areas with concentrations of low-income families, of satisfactorily promoting health of children and youth of school or preschool age;

(11) provides a program (carried out directly or through grants and contracts) of projects which offer reasonable assurance, particularly in areas with concentrations of low-income families, of satisfactorily promoting the dental health of children and youth of school or preschool age;

(12) provides for the development of demonstration services (with special attention to dental care for children and family planning services for mothers) in needy areas and among groups in special need;

(13) provides that acceptance of family planning services provided under the plan shall be voluntary on the part of the individual to whom such services are offered and shall not be a prerequisite to eligibility for or the receipt of any service under the plan;

(14) provides that, where payment is authorized under the plan for services which an optometrist is licensed to perform, the individual for whom such payment is authorized may, to the extent practicable, obtain such services from an optometrist who elects to perform such services except where such services are rendered in a clinic, or other appropriate institution, which does not have an arrangement with optometrists so licensed.

(15) provides with respect to the portion of the plan relating to care and services authorized under Sec. 503, for payment by the treated child's family or legal guardian or by third parties of that portion of the costs not paid by the Secretary pursuant to Sec. 503(d), or Section 503(e);

PAYMENT TO THE STATES

Sec. 506(a) From the sums appropriated under Sec. 503 and Sec. 504, the Secretary shall pay to each State which has a plan approved under Sec. 505, for each quarter, an amount, which shall be used exclusively for carrying out the State plan

(b)(1) Prior to the beginning of each quarter, the Secretary shall estimate the amount to which a State will be entitled under Subsection (a) for such quarter, such estimates to be based on—

(A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of subsection (a), and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived; and (B) such other investigation as the Secretary may find necessary.

(2) The Secretary shall then pay the amount so estimated to the State in such installments as he may determine proper, provided that, such amount shall be reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection.

(3) Upon the making of an estimate by the Secretary under this subsection, any appropriations available for payments under this section shall be deemed obligated.

OPERATION OF STATE PLANS

Sec. 507. If the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of the State plan approved under Sec. 505 finds—

(1) that the plan has been so changed that it no longer complies with the provisions of Sec. 505; or

(2) that in the administration of the plan there is a failure to comply substantially with any such provision the Secretary shall—

(1) notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure), until he is satisfied there will no longer be any such failure to comply; and

(2) shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure) until he is satisfied that there will no longer be any such failure to comply.

SPECIAL PROJECT GRANTS FOR HEALTH OF SCHOOL AND PRESCHOOL CHILDREN

Sec. 508. (a) For the purposes of this section there is authorized to be appropriated for the fiscal year ending June 30, 1973, and for each of the four succeeding fiscal years $50,000,000.

(b) Funds appropriated under this section shall be used for grants to promote the health of children and youth of school or preschool age, particularly in areas with concentrations of low-income families.

(c) Grants authorized under this section shall be made to the State health agency of any State and (with the consent of such agency) to the health agency of any political subdivision of the State, to the State agency of the State administering or supervising the administration of the State plan approved under section 505, to any School of medicine (with appropriate participation by a school of dentistry), and to any teaching hospital affiliated with such a school.

(d) Grants authorized under this section shall not exceed 75 per centum of the cost of any project for which grants are made.

(e) No project shall be eligible for a grant under this section unless it provides—

(1) for the coordination of health care and

services provided under it with, and utilization (to the extent feasible) of, other State or local health, welfare and education programs for such children;

(2) for payment of the reasonable cost (as determined in accordance with standards approved by the Secretary) of inpatient hospital services provided under the project, and

(3) that any treatment, correction of defects, or aftercare provided under the project is available only to children who would not otherwise receive it because they are from low-income families or for other reasons beyond their control; and unless

(4) it includes [subject to limitations in subsection (c) (1) (2) (3)] at least such screening, diagnostic, preventive services, treatment, correction of defects, and aftercare, both medical and dental, as may be provided for in regulations of the Secretary.

(f) The Secretary shall make such regulations as are necessary for the purpose of administering the grants authorized under this section.

SPECIAL PROJECT GRANTS

Sec. 509. (a) For the purposes of this section there is authorized to be appropriated for the fiscal year ending June 30, 1973, and for each of the four succeeding fiscal years $25,000,000.

(b) Appropriations authorized under this section shall be allotted by the Secretary in each fiscal year such that—

(1) $5,000,000 shall be available for grants to State agencies administering or supervising the administration of a State plan approved under section 505 for the provision of family planning services;

(2) $10,000,000 shall be available for grants to State agencies (administering or supervising the administration of a State plan approved under section 505), and to public or other nonprofit institutions of higher learning (situated in any State), for special projects of regional or national significance which may contribute to the advancement of services for children who are crippled or who are suffering from conditions leading to crippling; and

(3) $10 million shall be available for grants to State agencies (administering or supervising the administration of a State plan approved under sec. 505) and to public or other nonprofit institutions of higher learning (situated in any State) for special projects of regional or national significance which may contribute to the advancement of maternal and child health.

(c) The Secretary shall make such regulations as are necessary for the purpose of administering the grants authorized under this section.

TRAINING OF PERSONNEL

Sec. 510 (a) For the purposes of this section there is authorized to be appropriated for the fiscal year ending June 30, 1973 and for each of the four succeeding fiscal years $20 million.

(b) From the sums appropriated under this section the Secretary is authorized to make grants to public or nonprofit private institutions of higher learning for training personnel for health care and related services for mothers and children, particularly mentally retarded children and children with multiple handicaps.

(c) In making grants authorized under this section, the Secretary shall give special attention to programs providing training at the undergraduate level.

(d) The Secretary shall make such regulations as are necessary for the purpose of administering the grants authorized under this section.

RESEARCH PROJECTS RELATING TO MATERNAL AND CHILD HEALTH SERVICES AND CRIPPLED CHILDREN'S SERVICES

Sec. 511(a) For the purposes of this section there is authorized to be appropriated for the fiscal year ending June 30, 1973 and for each of the four succeeding fiscal years $10 million.

(b) With the funds appropriated under this section the Secretary is authorized to make grants to or make jointly financed cooperative arrangements with public or nonprofit institutions of higher learning, and public or nonprofit private agencies and organizations engaged in research or in maternal and child health or crippled children's programs, and contracts with public or nonprofit private agencies and organizations engaged in research or in such programs, for research projects relating to maternal and child health services or crippled childrens services which show promise of substantial contribution to the advancement thereof, provided that—

(1) special emphasis shall be accorded to projects which will help in studying the need for, and the feasibility, costs, and effectiveness of, comprehensive health care programs in which maximum use is made of health personnel with varying levels of training, and in studying methods of training for such programs; and

(2) grants under this section may also include funds for the training of health personnel for work in such projects.

(c) The Secretary shall make such regulations as are necessary for the purpose of administering the grants authorized under this section.

ADMINISTRATION

Sec. 512 (a) The Secretary shall make such studies and investigations as will promote the efficient administration of this title.

(b) Such portion of the appropriations authorized under this title as the Secretary shall determine, but not exceeding one-half of 1 percent thereof, shall be available for evaluation by the Secretary (directly or by grants or contracts) of the programs for which such appropriations are made.

(c) Any agency, institution or organization shall, if and to the extent prescribed by the Secretary, as a condition to receipt of grants under this title, cooperate with the State agency administering or supervising the administration of the State plan approved under title XIX in the provision of care and services, available under a plan or project under this title, for children eligible therefore under a plan approved under title XIX.

OBSERVANCE OF RELIGIOUS BELIEFS

Sec. 513. Nothing in this title shall be construed to require any State which has any plan or program approved under, or receiving financial support under, this title to compel any persons to undergo any medical screening, examination, diagnosis, or treatment or to accept any other health care or services provided under such plan or program for any purpose (other than for the purpose of discovering and preventing the spread of infection or contagious disease or for the purpose of protecting environmental health), if such persons object (or, if such person is a child, his parent or guardian objects) thereto on religious grounds.

Mr. SCHEUER. Thank you very, very much, Dr. Bergman. We appreciate your testimony. Perhaps you can hang around and when we go off the record we can include you on some of these panels at the end of the morning session.

Thank you.

Mr. SCHEUER. Our second witness will be Dr. Saul J. Robinson, clinical professor, department of pediatrics, University of California Medical Center.

STATEMENT OF SAUL J. ROBINSON, M.D.

Dr. ROBINSON. Thank you.

Mr. SCHEUER. Your testimony will be printed in its entirety in the record. You might wish to just chat informally, as your predecessor did [see p. 120].

Dr. ROBINSON. Dr. Bergman was so informal that I think that would be a real danger to me.

Mr. Scheuer, I want to thank you for the dinner last night. As you said, I am Saul Robinson, a pediatric cardiologist and clinical professor of pediatrics at the University of California school of medicine. I am testifying today as president of the American Academy of Pediatrics, an international medical association and children's advocate representing about 20,000 physicians dedicated to the care of infants, children and adolescents, many of whom are in this room.

The American Academy of Pediatrics is grateful for this opportunity to once again offer its comments on the Maternal and Child Health Care Act. The academy has a continuing commitment to achieving the highest possible standards of pediatric care, education and research, which hopefully will be shared by the sponsors of this bill, and most particularly by you. It has long been the academy's position, as is your position that I know so well, that our children are this country's most valuable resource and that dollars invested in children's health benefits are the most cost-effective health care funds this country can spend, yielding benefits in the form of a healthy population far into the future.

The academy last testified on the Maternal and Child Health Care Act during 1976 and since that time our basic position have not changed. Everyone agrees that preventive care for children, coverage for inpatient and outpatient services for infants and children and coverage for care during pregnancy are pediatric community priorities, and provisions for meeting these needs through a comprehensive approach are necessary. Preventive care is especially important, its absence sometimes having a permanent negative effect on health.

For a general statement on this, an informal statement on this bill, we wish to commend it, but we want to point out, as Dr. Bergman did—but not quite as emphatically, and I do not have the figures—but a large and significant number of children in this country are receiving adequate care and that your target, I am sure, is those people whom you mentioned who were not receiving immunizations nor receiving medical care. I don't see anywhere in your bill, I don't see anywhere in some of the testimony, the statement that a large number of people in this country are enjoying good health thanks to good health care and thanks to adequate health insurance.

The academy feels strongly that a trend toward lessened Federal funding of children's health programs while funding for other age groups increases must be reversed.

The academy regards as a positive sign your act's provisions in the area of health supervision, which we feel is the keystone of comprehensive health care for children. A commitment to health supervision and disease prevention will not only keep our children healthier and guarantee their full participation in life, but will also minimize costly hospitalization through prevention or alleviation of disease and suffering.

The academy has long considered child health to be a legislative priority of the first order for those individuals who are not receiving it. We heartily support your efforts in addressing that problem and hopefully that you will maintain your interest in the child as long as you are in Congress.

Mr. SCHEUER. I would certainly appreciate your continuing input into the work that my own office does and that our committee does. I assure you that I and other members of the Health and the Environment Subcommittee will continue to have a deep concern for children. We all hear that our society is supposed to be child-oriented. We are constantly using the cliche that our children are our future. If that is to have any meaning, I think we have to put our money where our mouth is. Perhaps you can continue to help us do that in a meaningful way.

Dr. ROBINSON. I accept the invitation. It will be implemented very soon.

Mr. SCHEUER. Very good. We welcome it.

Dr. ROBINSON. In June of 1976, we proposed some modifications, which you will remember, and some of which are now in this bill. Some of these modifications are an expanded advisory board, liberalized drug benefits and dental coverage, as Dr. Bergman mentioned. They have been addressed in your bill, but the comprehensive nature of this bill calls for additional changes, changes which would elicit more enthusiastic medical community support and better serve children and their families.

Let me begin by pointing out that experience with medicaid, including implementation of EPSDT, indicates that a major impediment in carrying out these programs is a lack of understanding on the part of eligible recipients. Failure to participate in EPSTD, failure to keep appointments for health supervision, with which we are all familiar, neglect of immunization and misuse of emergency rooms for routine health care; these are all factors indicative of the need for a strong health education component in this mother's and children's bill.

Mr. SCHEUER. Let me interrupt you for a moment on one point. You talk about misuse of an emergency room for routine health care. Aren't you saying that poor people don't have a family doctor down the block and that their only opportunity of getting routine, but necessary health care is in the emergency room of the local hospital?

Dr. ROBINSON. No; I don't say that. I say that if these people were educated to the availability of medical care in this community, they would find themselves a private physician, an available private physician, who would give them this care. We find that our experience with the child health disability program in this State, which I hope

will some day become a model and will be incorporated in your act, that the health care of children can be given adequately and under better circumstances in clinics, private physician's offices, groups, prepaid health programs, such as we have in California, and that they need not go to the emergency room for the episodic care which they are now receiving. The impact of your bill is preventive care and comprehensive care and emergency room care is neither adequate nor comprehensive.

Mr. SCHEUER. Let me ask one more question at this time. One of the problems that we have had in the medicare program is that physicians have not taken assignment and the patient ends up paying a substantial portion of the bill, contrary to the intention of Congress and the administration.

It happens this way. First of all, the physician charges a patient what he wants. The patient then takes the bill and he pays it. He sends it in for reimbursement. If he was charged $100, he is entitled to 80 percent and he hopes to get $80 back. But then the administrators of the program often disallow part of that charge as unreasonable. Instead of $80, the patient gets $50 back because they say the original charge was too much. Now, wouldn't we be asking for the same problems in this program if we don't require physicians to agree if they want to be paid by the program that they will accept the payment from the program, and the limited copayment, as full payment? They should accept the schedule fee payment as full payment and not bill the patient for something that will ultimately turn out to be unreimbursable. That has been a serious problem in the medicare program.

Dr. ROBINSON. You have mentioned in your bill that persons seeking care from physicians who elect to remain nonparticipants will not be entitled to benefit coverage under the plan. In that same bill you say, and I quote:

> Freedom of any physician or any patient to choose where and how they will give or receive health care could lead to a dual system of care which may not be in the best interests of the patients.

You can't give them freedom of choice and then tell them they can only go to certain physicians who have accepted consignment. I think that the financial arrangements, which I am going to come to later, may well be the crux of this.

Mr. SCHEUER. Based on the experience under the medicare program where physicians have not been happy with the fee schedules, how many physicians do you think would accept assignment?

Dr. ROBINSON. If the fee schedule were adequate, I can assure you that the pediatricians, and I can't speak for the obstetricians, but they would accept consignment almost totally. I think that the problems, and I digress, of care under EPSDT, under medicare, are forms of total lack of response to bills. You heard last night that some of the bills are as long as 6 months, 9 months, and are inadequate fees. The Government starts out with a statement in its act, and I was going to avoid a discussion of fees, of reasonable and usual fees. Then it takes 60 percent off of that and 40 percent off and 10 percent off and demands 11 forms. By that time, the physician is faced with the fact of taking a real and significant loss, particularly the pediatrician, every time he sees a patient. If you can obviate this, then I can assure you, on behalf of my colleagues, that they will all participate.

Dr. Bergman mentioned the problems of EPSDT and you admit that EPSDT, except possibly in the State of California, where we have a child health disability program, is an attempt to address itself to some of the deficiencies which you have already found. We view health education, as I told you, as very important. I sometimes wonder if more health education and less money directed to medical care might not benefit both the provider and the consumer.

Mr. SCHEUER. Particularly nutrition education.

Dr. ROBINSON. Well, I think that nutrition is very important.

Mr. SCHEUER. Diet and exercise.

Dr. ROBINSON. One of the questions we would like to ask you, and you answered indirectly in the bill, is our concern regarding the fate of the maternal and child health services now in place in the States through title V and other public funding by Federal, State, and local governments. Does this act replace them? What happens to medicaid funding of maternal and child health services? What is the interrelationship of these programs and how can they be defined?

I certainly agree with Dr. Bergman as to the superb crippled children's programs throughout most of the States, but there are some deficiencies as well. I hope that the entire concept regarding the program is not destroyed by an act which will replace it completely.

Mr. SCHEUER. We can assure you that this bill would not displace or wipe out those programs that you have mentioned. It will not.

Dr. ROBINSON. We have an established Academy policy that the benefits of any form of national health care should extend to age 21. This is despite the fact that the voting age is now 18. Such a provision would insure that college students and other children living away from home would have ready access to medical care. Though most consider adolescence the healthiest period of life, you yourself have just pointed out some of the problems that youth have and they can ill afford to be without adequate medical care at a critical age. They need the care of the individual who has taken care of them for the previous few years. I commend you on the fact that you have at least raised the level to a more appropriate age of 18. We hope it will become 21.

The bill's definition of preventive child health services should be amended to make it clear that screening, as provided, should be within the continuum of care received by children in their medical home and that such activities should not be conducted independently of a health service delivery system.

Mr. SCHEUER. In their medical home?

Dr. ROBINSON. Medical care, physician, clinic, prepaid health insurance. By medical home, the definition of medical home is a place where a child is taken when he is sick and which at the present time you admit and I admit for a significant number of the population is not available.

Mr. SCHEUER. Or is the emergency room.

Dr. ROBINSON. That is right. Screening is only one aspect of comprehensive child health care and should not be isolated as an independent service. I can't reiterate this too much. The deficency of EPSDT was too much emphasis on early periodic screening and forgetting the DT, diagnosis, treatment, and comprehensive care.

Mr. SCHEUER. In an absolutely astonishing number of cases the illness was identified, pinpointed, then nothing was done.

Dr. ROBINSON. Yes; despite the bill. The bill was a good bill. It was the way it was implemented.

Mr. SCHEUER. Yes.

Dr. ROBINSON. Under children's benefits, we would like to point out section 211(b), services not covered. Early intervention and treatment of mental disorders in children should be considered in the same fashion as services for physical disabilities. It is of questionable value to offer psychiatric benefits only through public or nonprofit community centers.

Mr. SCHEUER. What model do you think should be used?

Dr. ROBINSON. I just think they ought to be put into the same professional services in your 211(a) as are [illegible]ther professional services, dental care and medical care. I don't [illegible]hey should be excluded. I think our mental illnesses are one of [illegible]most important problems.

Mr. SCHEUER. So far the psychiatric profession, psychiatrists and psychologists, have really been unable to quantify illnesses and treatments and predict costs of treatment, course of treatments. It seems to me they are going to have to do something to help us get a handle on predicting costs and rationalizing treatment. Until that happens, as other people have put it, we cannot convert this bill into the psychiatric unemployment compensation bill of 1979. Just an open-ended access of the entire psychiatric profession to public funding, I think, is politically unfeasible and financially and fiscally unadvisable. So far the industry has really not heped us very much in rationalizing the quality of care and the cost of care and providing some kind of parameters of treatment and costs. I have asked them repeatedly to do it and so far we simply haven't gotten that kind of information.

Dr. ROBINSON. You are leaving it open?

Mr. SCHEUER. Yes; to plug an individual psychiatrist into a reimbursement system, I think, would open up a Pandora's box of problems in the Congress and in the executive branch. For the time being, we simply don't feel we can do that. It may be that in another year or two if the profession can come up to us with some guidelines as to what various kinds of mental illnesses are going to cost, how long the treatments will run, what the objectives of the treatment are, what the results of the treatment can be proven to be, if we can get that kind of rationalization and sort of a fine tune analysis of cost and benefits, I think we might move in that direction. It is my personal opinion that we aren't at that point yet. I hope we will be soon.

Dr. ROBINSON. What you need is more data, then?

Mr. SCHEUER. More data. Maybe you can prod your colleagues in the psychiatric profession to do that. Until they can, they are writing themselves out of participation in this kind of a bill. I don't think you would find a Member of Congress who was more sympathetic to the need of all of us for mental health as well as physical health. But I think the profession has to do some introspection and see how they are going to fit into the kind of cost controls and quality controls formulae that the Congress is going to use for health care. Maybe you can prod them to do this.

Dr. ROBINSON. Another point is the dental benefits where you first had the lower limit as four, then made three. We would question the placing of a lower level age limit on dental benefits under the act as stipulated in section 211. Dental consultation and intervention is vital to children born with cleft palates and lips almost from they time they are born. The only way it can be done is by a team approach, of which dental care becomes the most significant. If it isn't done in the early years, it can't be done at all. The damage is done. I hope that you may make either an exception or lower the age limits where appropriate and allow the medical profession to make the decision.

Mr. SCHEUER. For cleft palates?

Dr. ROBINSON. For cleft palates and harelips; yes.

Another point that I would like to make is that we like the bill's provisions for copayment which are consistent with the previously enunciated policy statements of the Academy of Pediatrics. That is that there be no deductibles or coinsurance for preventive care and that families above the poverty level should bear some financial responsibility and, further, that existing and appropriate forms of children care not be destroyed in an attempt to develop an entirely new form.

We feel that since physician extenders function under the supervision of physicians it is recommended that reimbursement under the program be directly to the responsible supervising physician or the institution, as it is in the rural health bill. Fiscal and legal responsibilities should be consistent. Section 36 on reporting should also delete reference to physician extender since, again, reporting should be through the responsible physician or the qualified institution.

The academy also favors the bill's provision for the use of fiscal intermediaries. This academy does not favor the social security approach to financing it. Unfortunately the fiscal intermediaries have, as everyone else, ignored the significant child health preventive benefits in their own coverage. The academy is prepared to offer to you expertise in helping determine a data base as to how one can best use a fiscal intermediary for the preventive services which are not now covered.

We are somewhat concerned about the area fee payment boards. In my written testimony, you will find our comments regarding the struggles of HSA's and PSRO's have made to establish themselves as effective regional authorities and we wonder if the same thing won't happen to the area fee payment boards.

I mentioned before the academy has serious reservations on the support of any bill which adds to the social security tax, which will soon add a staggering burden to the paychecks of all Americans. The only way this bill can be made palatable is to show that it will reduce other taxes Americans are now paying and relieve the States of some of the burden of medicaid.

We would urge reconsideration of the sections on covered diagnostic services since they appear to preclude the performance in the physician's office of certain simple laboratory services which may be reliably provided there with greater convenience and certainly reduced cost.

The academy also favors the inclusion in part C, maternity benefits, provisions for fetal diagnosis and treatment, both of which are essen-

tial components of modern maternal and child health care. We also favor a provision for preconception care, which can directly affect the fetus and the newborn child. Nutritional education, as you mentioned, and the treatment of diseases such as syphilis and gonorrhea prior to conception can give future generations the clean bill of health they deserve.

In conclusion, while the Academy of Pediatrics at this time is not prepared to fully support the bill as presently formulated, it wishes to commend your efforts particularly in an area we feel must be the foundation of any comprehensive national health program.

I thank you for being permitted to present our views.

Mr. SCHEUER. We thank you for taking the time and the effort to put together this very scholarly and thoughtful statement. Thank you very, very much, Dr. Robinson.

Dr. ROBINSON. Thank you.

[Dr. Robinson's prepared statement follows:]

Testimony of the

American Academy of Pediatrics

Before the

Subcommittee on Health and the Environment
Committee on Interstate and Foreign Commerce

January 3, 1978
San Francisco, California

Presented by

Saul J. Robinson, M.D., President

Mr. Scheuer, I am Saul J. Robinson, M.D., a pediatric cardiologist from San Francisco and Clinical Professor of Pediatrics at the University of California School of Medicine. I am testifying today as President of the American Academy of Pediatrics, an international medical association and children's advocate representing physicians certified in the care of infants, children and adolescents.

The American Academy of Pediatrics is grateful for this opportunity to once again offer its comments on the Maternal and Child Health Care Act. The Academy's continuing commitment to achieving the highest possible standards of pediatric care, education and research seems to be shared by the sponsors of this bill and we commend their approach. It has long been the Academy's position that our children are this country's most valuable resource and that dollars invested in children's health benefits are the most cost-effective health-care funds this country can spend, yielding benefits in the form of a healthy population far into the future.

The Academy last testified on the Maternal and Child Health Care Act during June 1976, and since that time our basic positions have not changed. Preventive care for children, coverage for inpatient and outpatient services for infants and children and coverage for care during pregnancy are pediatric community priorities, and provisions for meeting these needs through a comprehensive approach are necessary. Preventive care is especially important, its absence sometimes having a permanent negative effect on health.

The Academy feels strongly that a trend toward lessened federal funding of children's health programs while funding for other age groups increases must be reversed. Between 1960 and 1975, federal health dollars invested in child health declined from one of every two to one of every 10 spent. While federal expenditures for health increased seventeenfold, children saw their share of the pie only quadruple. The early, formative years require better health service, yet we still have not adopted a national policy for promoting health, preventing disease and illness and guaranteeing our youngest citizens the right to a healthy future.

The Academy regards as a positive sign the Act's provisions in the area of health supervision, a keystone of comprehensive health care for children. A commitment to health supervision and disease prevention will not only keep our children healthier and guarantee their full participation in life but also minimize costly hospitalization through prevention or alleviation of disease and suffering.

The Academy has long considered child health to be a legislative priority of the first order, and we heartily support your efforts in addressing that problem. In June 1976, we proposed several modifications to the current bill's forerunner. Some of those modifications -- an expanded Advisory Board and liberalized drug benefits and dental coverage -- have been addressed, but the comprehensive nature of this bill calls for additional changes, changes which would elicit more enthusiastic medical community support and better serve children and their families.

Let me begin by pointing out that experience with Medicaid, including implementation of EPSDT, indicates that a major impediment in carrying out these programs is lack of understanding on the part of eligible recipients. Refusal to participate in EPSDT, failure to keep appointments for health supervision, neglect of immunization and misuse of emergency rooms for routine health care are factors indicative of the need for a strong health education component in this Mother's and Children's Act. We view health education not only as an integral part of the entire concept of this Act but also as essential for cost containment in achieving a national health program.

Something should also be said in the bill concerning the fate of maternal and child health services now in place in the states through Title V and other public funding by federal, state and local governments. Does this Act replace them? What happens to Medicaid funding of maternal and child health services? The inter-relationship of these programs should be defined.

It is also an established Academy policy that the benefits of any form of national health care should extend to age 21. Such a provision would insure that college students and other children living away from home would have ready access to medical care. Though most consider adolescence the healthiest period of life, our youth can ill afford to be without adequate medical care at such a critical stage.

The bill's definition of preventive child health services should be amended to make it clear that screening, as provided, should be within the continuum of care received by children in their medical home and that such activities should not be conducted independently of a health service delivery system. One need only be reminded of EPSDT experiences in some areas, where screening is not closely coordinated with the community's public or private medical resources, to understand why this is a matter of concern. Screening is one aspect of comprehensive child health care and should not be isolated as an independent service.

Under children's benefits, covered professional services, psychiatric services should be moved from Section 211(b), services not covered, to Section 211(a), covered professional services. Early intervention and treatment of mental disorders in children should be considered in the same fashion as services for physical disabilities. It is of questionable value to offer psychiatric benefits only through public or non-profit community centers.

The Academy would question the placing of a lower-level age limit on dental benefits under the Act as stipulated in Section 211, part (2). Dental consultation and intervention is vital to children born with cleft palates and lips almost from the time they are born.

Under Section 211, part (3), we would recommend substituting "without consultation with a pediatrician" for "without a second consultation."

On page 34, Line 14, the Academy recommends omitting the qualifier "nonprofit" as it applies to organizations allowed to provide support services. In some parts of the country there simply are not enough nonprofit organizations to meet the demand for support services, and profit-making organizations must be used.

Regarding Section 213, we feel that strict standards should be applied to insure that institutions eligible to provide covered nursing home services meet special criteria to show they are capable of properly handling small children. Many of these institutions are not properly equipped or staffed to provide such care or a fitting environment for children.

Private-duty nurse care for inpatient and pediatric care occasionally may be medically indicated for certain youngsters, and when such is the case it should not be precluded as a benefit as per Section 212(b). The Academy would accept the provisions of Section 212(c) limiting inpatient service to 100 days annually, provided the Act takes into account the overwhelming burdens of health related catastrophies requiring lengthy inpatient services. The prospect for a productive, healthy lifetime should not be precluded by a benefit limitation which would result in little cost savings if retained. In those occasional incidents where more than 100 annual hospital days may be necessary, families might be unable to secure private coverage since the adoption of this bill could drive from the marketplace private insurance carriers which hitherto have written insurance benefits for children as part of family contracts.

Title III addresses payments for covered services. It appears that persons seeking care from physicians who elect to remain non-participants will not be entitled to benefit coverage under the plan. Payment will be made neither to the physician for services he provides nor to the patient for expenses incurred. This hardly seems consistent with the bill's provisions for "freedom of any physician or any patient to choose where and how they will give or receive health care" and could lead to a dual system of care which again may not be in the best interest of patients. It is recommended that the assignment and payment to patient provisions of Medicare be included to resolve this issue.

The bill's provisions for copayment (Section 305) are consistent with previously enunciated policy statements of the Academy: that there be no deductibles or coinsurance for preventive care and that families above the poverty level should bear some financial responsibility.

Since physician extenders function under the supervision of physicians, it is recommended that reimbursement under the program (Section 304) be directly to the responsible supervising physician or the institution. Fiscal and legal responsibilities should be consistent. Section 308 on reporting should also delete reference to physician extender since again reporting should be through the responsible physician or qualified institution.

The Academy also favors the bill's provision for the use of fiscal intermediaries. This has proved workable for Medicare, and that program's experience with providers will be an advantage. However, it should be pointed out that few if any fiscal intermediaries have had experience with the scope of benefits in this Act. Indeed Blue Cross, Blue Shield and private insurance companies have avoided including significant maternal or child health preventive benefits in their own coverage. The Academy recommends that the Act be modified to include in the standards required of fiscal intermediaries in order to qualify for participation in the Act that pediatric and obstetrical advice be a part of their organizations.

In addition, the screens for reasonable and customary fees to physicians used in Medicare are not appropriate for pediatricians and obstetricians who have for obvious reasons no cause to participate in Medicare. The Academy has recently experienced a problem with this very system in the state of Wisconsin. The Medicare screens were applied to pediatricians in that state and the fees allowed were totally unacceptable. As a possible alternative to the Medicare screens, the Academy would be willing to assist in securing nationwide data on which fee payment area boards could develop their fee payment schedules. It is not clear how these area boards will be created, but the bill appears to make it possible for an HSA or PSRO to establish an organization with this function.

The Academy also recommends that the Act give assurance that only qualified pediatricians and obstetricians will provide care under the Act. In its present form, any licensed physician can provide the benefits of the program, and this is a weakness, especially in view of the fact that the Act is very specific about the qualifications of hospitals. We also question the lack of standards for ambulatory care; this appears to be the heart of the program, which emphasizes preventive care in pediatrics as well as obstetrics.

The concept of fee payment schedules (Section 312) could be adopted in a national program of benefits for children, but it is important that reimbursement be consistent with prevailing fees in the area. It is proposed that the philosophy in establishing the reimbursement mechanisms for the program be one of adequate and appropriate reimbursement for a professional service. The utilization of December 1974 prevailing fees as a base for a program scheduled to begin no sooner than 1979 would

discourage the participation of many practitioners. And if that fee schedule is to be based on experience accumulated by the present fiscal intermediaries as mentioned above, the Academy finds this unacceptable. The bill's allowing for consideration of revision annually, however, is a good idea. We also commend offering capitation as an alternative to fee for service. We would point out, however, that the entire section relating to fee for service and capitation is very dependent on the organization and membership of the area fee payment board.

The system has theoretical appeal but rests heavily on the competence of the area fee payment boards. Anyone who is witnessing the struggles of the HSA's and PSRO's to establish themselves as effective regional authorities in health matters hesitates to endorse at this time creation of another quasi-public body with so much power over the private practitioner.

The Academy also has serious reservations on support of any bill which adds to the Social Security tax, which will soon add a staggering burden to the paychecks of all Americans. The only way this bill can be made palatable is to show that it will reduce other taxes Americans are now paying and relieve states of some of the burden of Medicaid.

We would urge reconsideration of the sections on covered diagnostic services since they appear to preclude the performance in the physician's office of certain simple laboratory services which may be reliably provided there with greater convenience and reduced cost.

The Academy also favors the inclusion in Part C, maternity benefits, provisions for fetal diagnosis and treatment, both of which are essential components of modern maternal and child health care. We also favor a provision for preconception care, which can directly affect the fetus and the newborn child. Nutritional education and the treatment of diseases such as syphilis and gonorrhea prior to conception can give future generations the clean bill of health they deserve.

In conclusion, the American Academy of Pediatrics commends your efforts in an area we feel must be the foundation of any comprehensive, national health program. We are grateful for the opportunity to present our views.

Mr. SCHEUER. Our third witness will be Dr. Phil Lee, director of the health policy program at the University of California School of Medicine, and a very distinguished former Assistant Secretary of the Department of Health, Education, and Welfare.

STATEMENT OF PHILIP R. LEE, M.D.

Dr. LEE. Thank you very much, Mr. Chairman.

I am accompanied by Dr. Peter Budetti, who you have come to know and who is an associate of mine at the health policy program.

Mr. SCHEUER. I want to again give our profound thanks to Dr. Budetti for his efforts in helping us together this entire set of hearings on quite short notice and over the holiday season.

Dr. LEE. The witnesses you have gotten, people like Dr. Robinson, Abe Bergman, Chuck Lewis, and others that you are going to hear, are evidence of the great interest in the issues that are raised by the bill and the importance that the individuals attach to child health and adequate maternal health care. We certainly believe, as Dr. Robinson and Dr. Bergman have indicated, that the present proposals before the Congress have given grossly inadequate attention to children, and to maternity benefits. It is extremely important that these hearings and other hearings be held to really identify even more thoroughly the issues that need to be finally addressed.

Mr. SCHEUER. You mentioned in your prepared statement the particular importance of family planning as an essential element of a health care program for women and children. I was the author of the 1970 Population Research and Family Planning Act whereby we set as a national goal the provision of family planning services to every American woman in her child-bearing years who couldn't afford them in the private sector. That was passed in 1970. By 1976, all women should have been covered, yet there are still almost one-third of all counties in the United States which do not have family planning services for poor women. They are almost all rural counties. And so there are still about 3.5 million women in their child-bearing years in this country who are unserved. I think there is an enormous unmet goal there. It is an anomaly that while fertility levels have gone down in almost every segment of the female population in this country, the fertility has gone up in terms of early childhood illegitimate births. So we have do do a great deal more than we have done, not only for mothers but also for teenage girls. The number of teenage girls that become pregnant each year, outside of the marriage bond, is growing. The average age at which they become pregnant is getting earlier and earlier and earlier. I am not quite sure what is responsible for this phenomenon, but when we have 300,000 illegitimate teenage births from age 12 to 15 or 16, I think we have a national problem of clear dimensions that threatens not only the lives and wellbeing of these young girls, but also of their children. I just couldn't let the opportunity go by without highlighting the fact that you did in your prepared testimony mention the importance of extending family planning to all women who need it.

Dr. LEE. We do stress that in the testimony. Also, I think it is appalling that we have now waited a year for the administration to come up with its so-called program on the pervention of unwanted pregnan-

cies. In his confirmation hearing, Secretary Califano made a commitment because of his personal objection to abortion. The President has made commitments on a number of occasions. Yet we have yet to see any program emerge from the Department of Health, Education, and Welfare. It is interesting.

Mr. SCHEUER. I might add that not only that, but they are downgrading the office of the Assistant Secretary of HEW for Population.

Dr. LEE. There is not even a Deputy Assistant Secretary any more.

Mr. SCHEUER. That is absolutely correct.

Dr. LEE. Of course Carl Schultz' death was a great loss. He was the most experienced person in the Department.

Mr. SCHEUER. And they have not replaced Lou Hellman.

Dr. LEE. No; we hear the words and, as Dr. Bergman has indicated, we don't see much of the action. I think it is a very serious indictment. If they are going to exert the kind of pressure that they have exerted, specifically the Secretary and the President, to prevent poor women from having the same access to abortion services that other women have, then they are obligated morally and from a public policy point of view to provide fully adequate alternatives. The fact is that they have not met those commitments. I think it is a sorry thing.

Mr. SCHEUER. It is a disgrace.

Dr. LEE. In any case, we do make a strong point about family planning services in the testimony.

One other point, early in the testimony we talk about the various groups that have conducted studies on child health or on children in recent years. Listed in that group are people like George Silver at Yale, with whom I have been associated for a good many years, who has done some outstanding studies on the implementation of maternal and child health programs at the State and local level; Ted Marmor, a political scientist at the University of Chicago, has made some very important contributions in analyzing the financing and the politics of health insurance coverage for children. Karen Davis, of course, when she was at the Brookings Institution, did outstanding work. She is one of the outstanding economists in the country and I am afraid that she has really not had the opportunity to express her own views on some of these issues, particularly as they relate to financing of care for poor kids. She has really looked at that problem. She is very knowledgeable about it.

Gil Steiner, also at Brookings, has taken a major look at child health. The Advisory Committee on Child Development of the National Research Council was chaired by Dr. Robert Aldrin, who was formerly the Director of the Institute of Child Health and Human Development, chaired that committee. They issued a major statement on a national policy for children, including a policy on child health.

Other groups have included the Childhood and Government Project at the University of California at Berkeley: the Child Health Project at Harvard, and more recently the Carnegie Council on Children. The Carnegie Council completed a 5-year study, a very extensive study on children, and has made a number of policy recommendations. Kenneth Kenniston, who chaired that council, is at MIT as a professor; Bob Haggarity, who was a member of that council, one of the country's most distinguished pediatricians, is at Harvard at the School of Public Health.

I think that all of these individuals and groups should be heard from, should be consulted on some of the issues that you have raised. I hope that the committee has a chance to do that.

The Children's Defense Fund also would be a very important resource. I know that you have worked closely with them, as you have with the Academy of Pediatrics. The academy is probably the most important single group outside of government working on these issues because, unlike many of the other professional groups, they really do advocate for children. I don't see the same kind of advocacy from the AMA, from the American College of Physicians, or other groups, for example.

There are just a couple of points in my testimony that I wanted to cover a little more in detail. We have already talked about family planning. The other one has to do with drug benefits. I would take, I think, a different view than the Academy of Pediatrics and that others have taken on the coverage of drugs and biologicals. Our colleague, Dr. Milton Silverman, who has been directing our studies on drugs for the last 5 years, and who worked with me in the Department of Health, Education, and Welfare, has recently finished a monograph called Drug Coverage Under National Health Insurance: The Policy Options. In that monograph, which was supported by the National Center for Health Services Research, he deals in depth with the major issue areas. Some of the issues I don't feel, are dealt with adequately in the legislation as it is currently drafted.

He discusses the selection of beneficiaries, the selection of covered drug products, cost sharing by the patient, reimbursement for acquisition of product cost to pharmacist. On that, for example, the bill uses the term "the wholesale cost" of a drug. There are certain sources of that at the present time, the so-called red book and blue book. The wholesale cost to the pharmacist varies widely and bears little relationship actually to those published wholesale costs. Chain stores are often able to make much better arrangements. They are able to acquire the products at much lower wholesale costs.

Sometimes the manufacturer sells directly to the retailer. Sometimes they go through wholesalers. There are various kinds of arrangements. I think that this is an area, as well as the others, that he has discussed. You deal with the reimbursement of the pharmacists. There are alternative reimbursement approaches that might be considered.

One of the problems is with the kinds of drugs that children use, the high cost of administering the drug benefit in relation to the prescription. A prescription that may cost $6 you will have an administrative cost perhaps as high as $2. In the absence of adequate data processing, we have relatively few drug insurance programs that have an adequate system of data processing so that these things can be handled on a fairly routine basis without manual data processing.

There are serious problems, I think, with respect to the drug benefits and the issues that relate to utilization review and quality control also need to be addressed. I don't see that they have been considered as thoroughly as we would hope.

This is an area certainly where we would be very glad to work with the committee staff in developing alternative approaches that the com-

mittee may wish to consider and perhaps doing some analysis specifically regarding drug utilization in children. This is an area that we know relatively little about.

Dr. Silverman in this monograph does document some of the figures on costs of drugs for kids. They are compared to the elderly very low.

One of my concerns about drug benefits is if they are unrestricted we may see things that are now purchased over-the-counter, like vitamins, become a prescription drug, and at significant cost with very little benefit.

I think we have to be very concerned about the use of certain drugs such as stimulants or amphetamines in obesity. I think they have absolutely no usefulness whatsoever. The FDA still approves them. The AMA Drug Evaluation, which is one of the best books on therapeutics, indicates in some selected cases they are still indicated. I think we have to be very concerned about what drugs are included to avoid the pressures on the physicians for overuse of the drugs. They will be pressured to prescribe the drugs that are covered. I think that is an area that needs some further analysis.

We don't have any definitive recommendations. We deal in the testimony with some of these specific areas, administration, scope of benefits and some of these other things. As I indicated, we would be pleased to work and continue to work with the committee.

I just want to say in closing, and to reiterate what Dr. Robinson and Dr. Bergman have both said about the importance of these hearings and the importance of this legislation in bringing the issues of not only health insurance for children, but child health back into the national policy agenda. We do not have a children's bureau any more. We do not have any advocates, as I can see it, for children, even though a pediatrican is now the Assistant Secretary for Health. His range of responsibilities is so great. I think it is clearly up to the Congress to take the initiative to hold a series of hearings, if possible, to bring the issues to the public's attention so that the kind of constituency that you talked about with Dr. Bergman might emerge. It isn't going to emerge from the National Council of Senior Citizens. It isn't going to emerge from the other organized groups.

You will be hearing from one of the more effective children's lobbies in the United States when Dr. Delmer Pascoe testifies later today on the Children's Lobby in California. Those kinds of groups that you are providing an opportunity to be heard, as well as the professional groups such as the Academy of Pediatrics, are important. It is impossible to develop effective advocacy unless there is some focal point for that concern to be expressed.

Thank you very much.

[Testimony resumes on p. 144.]

[Dr. Lee's and Dr. Birdetti's prepared statement follows:]

STATEMENT BY PHILIP R. LEE, M.D., PROFESSOR OF SOCIAL MEDICINE, DIRECTOR, HEALTH POLICY PROGRAM, SCHOOL OF MEDICINE, UNIVERSITY OF CALIFORNIA, SAN FRANCISCO (UCSF); AND PETER BUDETTI, M.D., J.D., ADJUNCT ASSISTANT PROFESSOR OF HEALTH POLICY, UNIVERSITY OF CALIFORNIA, SAN FRANCISCO (UCSF)

Mr. Chairman and members of the Subcommittee, we are pleased to appear before the Committee to testify on the Maternal and Child Health Care Act (H.R. 1702) as well as the changes that have been proposed. We would like to make it clear at the outset that we are here as interested individuals and not as representatives of the University. It is our understanding that the purpose of these hearings is to aid in the shaping of that legislation, not to solicit support for the bill.

The Act (H.R. 1702) and the hearings held by the Subcommittee on Health and Environment of the House Interstate and Foreign Commerce Committee provide an unparalleled opportunity to consider major issues related to maternal and child health, and, hopefully to advance the cause of maternal and child health. Not since the enactment of the Social Security Act in 1935, with its provision for crippled children and maternal and child health has the opportunity been as great as it is today.

In recent years, significant studies have been devoted to analyzing child health needs and the means of meeting these needs. Health insurance is only one, and not the most important means of meeting the health needs of children.

In recent years, significant studies have been carried out by Dr. George Silver at Yale; Professor Theodore Marmor, University of Chicago; Dr. Karen Davis when she was at the Brookings Institution; Dr. Gilbert Steiner of the Brookings Institution; the Children's Defense Fund; the Advisory Committee on Child Development of the National

Research Council; and the Harvard Child Health Project. Most recently, the Carnegie Council on Children completed its five-year study on children in America. All of these groups or individuals should certainly be consulted.

The Academy of Pediatrics has for years examined problems related to child health and health care. Few other medical groups have been as consumer oriented, and I know you will be consulting with them as you consider this legislation further.

The development of a national policy for child health has been retarded for several reasons. First, because we have been unwilling to really examine the importance of behavioral, sociocultural and environmental factors in relation to child health. Too much emphasis has been placed on medical care as the principal means of achieving the desired goals and not enough on income support, social support systems and education. In my view, the funds that have been spent on food stamps, school lunch programs and the Special Nutrition Programs for Women, Infants and Children have probably done as much, or more, than the funds spent on medical care to improve child health.

The second problem has been the unwillingness of the federal and state governments to adequately fund needed preventive health services. At the top of the list, I would put Family Planning Services, including abortion. Long the stepchild of publicly provided medical care services and neglected by many community hospitals and private physicians, family planning services have been critically important in the sharp decline in the infant mortality rate that has occurred during the last

decade. Immunization programs have also been neglected; flouridation of community water supplies is lagging and preventive dental services are really available only for children in middle and upper income families. Adequate prenatal care remains a problem for many poor people, particularly minorities because they do not have ready access to services, and instead of receiving care beginning in the first trimester they may not initiate care until the last months of pregnancy or at the time of childbirth.

I will begin by commenting on several issues regarding the relation of provisions in the proposed bill to a future NHI program.

The specific areas that I will comment on include the proposed administrative structure, which I feel would set up a redundant new bureaucracy that could make the problems of coordination more difficult and might actually impede development of a generalized program. I will also discuss my concern that the bill would prove so costly that it would delay movement toward more comprehensive coverage. After reviewing these issues, I will comment on several specific areas covered by provisions in the proposed bill including:

-- Scope of Benefits and Population covered:
  - Family Planning Services
  - Co-payments
  - Inpatient Services
-- Manpower Issues
-- Drugs and Biologicals

In addition, at several points in the discussion, I will raise questions as to whether the limited incentives offered for capitation payment and group practice are sufficient to stimulate needed reforms of the present delivery system.

RELATIONSHIP OF PROPOSED BILL TO A GENERAL NATIONAL HEALTH INSURANCE PROGRAM

This act is specifically intended to serve as a stepping-stone to a general program of national health insurance. It is important, then, to ask whether setting up a limited program for mothers and children would in fact facilitate development of universal insurance. Many of my comments today will be directed toward answering that question. Although I certainly endorse the goal of assuring that all mothers and children receive necessary therapeutic and preventive medical services, I share your concern that this be done as part of a universal comprehensive health insurance program. For that reason, I would like to touch upon a few potential problems presented by any proposal for a limited program for mothers and children only.

Over the past 12 years, we have taken several important steps toward the development of a comprehensive, universal national health insurance program. The approach has been incremental beginning with the aged and the poor who were eligible for public assistance. Other important steps were taken to improve the organization of care, target services to low income groups, and provide the needed facilities and health manpower to meet the growing demand. Where payment mechanisms and traditional approaches failed to reach people in need, as with family planning services, categorical programs were developed.

It is important not only to ask the question - what next, but to consider in detail whether or not it is logical to extend coverage to children and women needing maternity care. While it is clear that preventive health measures are likely to have an impact on children

and pregnant women; many persons who would be covered by this program, particularly those from middle and upper income families, already have nearly full access to both preventive and therapeutic medical care. A much needier group is mothers and children in the poverty or working-poor classes. In spite of substantial expenditures on behalf of the poor, there is still a large gap in health status between the income classes. Although much of the disease burden of poorer populations is preventable through social measures such as adequate income maintenance, food stamps, jobs and housing, medical care also has an important role to play. It must be considered, however, in relation to these other effects. Narrowing this gap through medical care requires strengthening screening programs, increasing the incentives for practitioners to provide continuing care to low-income patients, particularly paying primary care physicians adequately for the services they provide, and developing the educational, transportation, and other support services needed to increase access to medical services for this group.

In light of this, I believe that reforms in existing programs directed toward these goals are a higher national priority than expanding coverage to all socioeconomic classes.

The proposed bill, of course, recognizes the needs of these high-risk groups. The proposal to provide additional support services to special populations is precisely the kind of action needed. If the committee decides that it is not appropriate at this time to proceed with the entire plan for mothers and children, I would encourage it to incorporate the benefits to special populations into necessary reforms of the present Medicaid program and the other programs which

pay for and deliver care to the lower-income groups.

Administration of the Act

The administration of the National Health Insurance Program for Mother and Children and its relationship with other existing programs for mothers and children present a number of serious problems.

The Act establishes in the Department of Health, Education, and Welfare, an Administration for National Health Insurance for Mothers and Children to be headed by an Assistant Secretary for National Health Insurance for Mothers and Children, appointed by the President. This will create an administration separate from the Health Care Financing Administration (HCFA), which was created to administer the Medicaid and Medicare programs and assure more effective coordination of policies and improved management. Using the existing resources within HCFA to administer the proposed health insurance program would make more effective use of the scarce management talent available to carry out these highly complex tasks. As a former Assistant Secretary for Health and Scientific Affairs, I think this question needs to be explored more carefully with officials in the Department of Health, Education, and Welfare as well as in the states and the private sector.

I suggest that the Committee explore creation of an integrated Administration within HCFA to handle the proposed Maternal and Child Health Insurance Program along with Medicare and Medicaid. This administration might also handle related health care funds under Title V (Maternal and Child Health and Crippled Children's Services), and Title XX of the Social Security Act, Title X of the Public Health Service Act, (Family Planning Programs), and the Developmental Disabilities Services

and Facilities Construction Act.

Combined administration of these programs would simplify problems of eligibility and benefits and minimize duplication of coverage. The problems are complex, however, because of the variety of relationships and arrangements that have developed with states and local government as well as providers of care. If the bill is to serve as a major stepping-stone to NHI, however, its mandate should go beyond combined administration to the consolidation of all services for mothers and children into one program. While this represents a radical departure from the traditional incremental approach to the financing and provision of health services, it is imperative that each step towards NHI consolidate those programs that serve the same groups. As a major step to minimize fragmentation and establish the base for program consolidation that is essential for a comprehensive NHI program, the bill could encompass all services presently available under the different programs rather than simply providing that no payments be made under Medicaid for any service covered under the new act. This could be done by guaranteeing that the new plan will provide all services that the other programs now allow. Or, the new plan would define and cover those services determined to be of sufficient benefit and existing services not of sufficient benefit would be deleted.

It is essential to recognize, however, that payment alone will not do the job. The kind of relationships that have developed through the Crippled Children's Program and the Family Planning Program illustrate the kind of outreach, follow-up and quality control that should be an integral part of any program.

How much money would be necessary to fund the services proposed by this bill? I cannot give a precise answer, but a total cost somewhere in the $10-$20 billion range seems likely. Total personal health expenditures in FY 1976 for persons under 19 were estimated to be $17.9 billion by the Social Security Administration. Federal, state and local governments provided about one-fourth of that total. Given the rise in medical care prices, a figure in excess of $20 billion would be more realistic for the current fiscal year. However, the proposed bill would not cover all personal health care expenditures, and that will cut the cost of the bill to some degree. On the other hand, the bill's extensive benefits in the face of a nominal co-payment are likely to increase utilization substantially, thereby increasing total costs.

Another gross estimate of costs can be based upon projections of the costs of funding a program with similar benefits for residents of the state of Maryland. Using those projections and assuming no co-payments, no changes in existing delivery patterns or utilization levels, it is estimated that a national plan covering mothers and children up to age 6 would have cost $16.7 billion in 1976.

Neither of these estimates take into account the effect on expenditures of several cost containment mechanisms included in the bill. If the proposed fee schedules were based upon the most efficient providers in the community and utilization of services were adequately monitored, there might be substantial savings. I believe that the Professional Standards Review Organizations (PSROs) should be given

responsibility for monitoring the appropriateness and medical necessity of care under this act, rather than duplicating their function with an additional review mechanism. The use of physician extenders may serve to control costs although their ability will be limited if there is no incentive for non-physicians to provide services at a lower cost or if they are required to purchase physician consultation as a prerequisite to practice. The incentive for capitation payment is potentially cost-saving, although it would not save money in the short run since it pegs capitation at 10 percent over the fee schedule level. (Presumably this is a short-range inducement for the development of capitation systems). Finally, the requirement for prospective budgeting by participating hospitals should help to limit future cost increases. However, it is unclear how much savings would result from these cost-containment tools. Although they are clearly a step in the right direction, little in the way of hard evidence exists to indicate whether the savings resulting from these devices would outweigh the increases in utilization caused by the introduction of a broad benefit package with a minimal co-payment provision.

Because of the very large sums involved and the uncertainty of the savings to be realized through these mechanisms, I am concerned that this bill would divert attention and resources away from comprehensive national health insurance, rather than serve as a stepping-stone to the larger program. I would recommend that the committee continue its consideration of the issues raised in these and earlier hearings and begin to explore possible alternatives.

SCOPE OF BENEFITS AND POPULATION COVERED

Family Planning Services

A critically important omission is the lack of specific coverage for family planning services. It is essential, in my view to include the full range of voluntary fertility-related services, that is, contraceptive services, abortion, sterilization and the treatment of infertility, as well as maternity care. However, except for pregnancy testing which is a covered service available to any woman, only pregnant and recently pregnant women (up to 12 weeks) are eligible for benefits.

As far as contraception is concerned, pregnant women have little need for contraceptive services. This means that family planning services could only be provided during the period following the pregnancy. But, since coverage in the bill is restricted to the "diagnosis and treatment of any injury, disability, or disease related to pregnancy" during the 12-week period immediately following the pregnancy (Sec. 221.(3)), even then contraceptive services would not be routinely available at the postpartum checkup or in the first 12 weeks following childbirth. It does appear that spontaneous abortions would be covered under the provision which covers "the diagnosis and treatment of any injury, disability or disease during pregnancy" (Sec. 221 (2)).

As the bill emphasizes preventive health services for children 18 years old and under, contraception and abortion services could, at least theoretically, be provided to them. (There is a ban on the use of federal funds for the sterilization of persons under 21.)

When it comes to sterilization, a woman could only be sterilized

during the 12 weeks following pregnancy, which for practical purposes means following childbirth, and even then only when necessary as a treatment for a complication related to the pregnancy. Finally, it clearly does not cover the medical treatment of infertility.

Finally, as Ms. Jeannie Rosoff, Vice-President for Governmental Affairs, Alan Guttmacher Institute, wrote to you last August:

> "There is another flaw which would create serious problems in the implementation of family planning programs under the bill and which would have a severe and negative impact on maternal and child health programs as well -- that is, the exclusion of clinics (even outpatient clinics in hospitals) which provide most preventive services rendered (other than in a doctor's office). Under the bill even "well baby" clinic services would not be covered."

The bill should provide all family planning services necessary, including abortion and sterilization, to enable women to bear children when and as often as they choose. For some, certainly this would mean delaying their first child until the optimal age for parenting. Under the present language, it is not clear whether any family planning services are covered. If the bill is to have a major impact on maternal and infant mortality and morbidity, it must provide family planning services, including abortion. It should cover contraception for women of all childbearing ages, so that it will be easier for women to delay or avoid unwanted pregnancy, including teenage pregnancy.

Co-payments

The bill precludes co-payment for preventive services, for services to low-income recipients, and for services in a capitation system. These provisions are consistent with the basic purposes of the act and established federal policies to stimulate development of prepaid

group practices and Health Maintenance Organizations (HMOs). The 10 percent co-payment allowable for other services for persons above the poverty level, however, may be too high for the near-poor and too low for higher income groups. In order to insure that the near-poor are not deterred from using needed services and that the non-poor do not over-utilize medical services, the Committee should consider other alternatives, including incorporating a sliding coinsurance scale, with the family's share increasing with family income.

Inpatient Services

The bill would limit inpatient services for children to 100 days annually. This provision would save very few public dollars, since the overwhelming majority of hospital stays for children are of a very brief duration. On the other hand, it would inflict great financial hardship on the few families whose children are stricken with very serious illnesses. The bill should provide adequate catastrophic coverage by deleting the limit on days of acute medical care.

MANPOWER ISSUES

The key to meeting the demands for ambulatory care that would likely follow enactment of H.R. 1702 is the supply of physicians, particularly pediatricians and family practitioners. The rapid expansion of medical school enrollments in this past decade, the doubling of the number of medical school graduates, and the rapid increase in those going into pediatric and family practice training programs provide a basis for optimism, although there may be some areas of the country that will continue to experience a shortage of primary care physicians. I believe that the future availability of obstetricians, family practitioners, nurse midwives and other professionally trained midwives should also prove adequate to meet the needs for maternity care.

I believe the bill takes several commendable steps with regard to non-physician practitioners. From the present language, it appears that physician extenders are eligible for direct payment for services they provide. While I support such developments toward providing fair compensation to all practitioners, I feel that non-physicians should ordinarily be reimbursed in an organized setting or practice arrangement which provides direct access to physician supervision and care when necessary. I believe that physician extenders should work collaboratively with physicians, and would not recommend expanding the payment provisions to cover care offered in a setting wholly independent of physicians. While there is a need to reduce unnecessary physician dominance where it exists, the interests of mothers and children would not be served by funding a fully competitive alternative practitioner network.

The one exception to this policy would be direct reimbursement for organized maternity services for prenatal care and childbirth for mothers with low risk pregnancy. Such organizations as the Maternity Association in New York City have demonstrated the feasibility and appropriateness of this approach.

DRUGS AND BIOLOGICALS

The sections (217 and 224) describing the coverage of drugs and biologicals remain unclear. Initially, prescription drug benefits would have been limited to drugs required for four weeks or longer. Subsequently, this provision was eliminated and coverage was limited to drugs prescribed to be taken for a chronic disease or condition, or for a disease or condition where the Secretary determines the drug or biological required is costly. It is not clear if the provision relating to chronic disease has now been eliminated, leaving coverage to be determined by the Secretary based on cost.

Drug coverage under NHI is a complicated subject. Doctor Milton Silverman has been directing the Health Policy Program's study of this subject for the past several years and he has recently written a memograph, Drug Coverage Under National Health Insurance: The Policy Options, for the National Center for Health Services Research. This monograph was published in the fall of 1977, and it covers the subject in detail. Issues considered include:

- Selection of Beneficiaries
- Selection of Covered Drug Products
- Cost Sharing by the Patient
- Reimbursement for Acquisition or Product Cost to Pharmacist
- Reimbursement for Dispensing Cost by Pharmacists
- [redacted] Reimbursement Approaches
- Reimbursement Methods
- Data Processing

- Control of Program Quality: Utilization Review - Combination Approach

These issues must be addressed in any bill including drug coverage, and yet, I do not find the bill sufficiently clear on a number of these questions. For example, I did not find anything relating to a formulary, drug utilization review, quality control. The reimbursement of pharmacists is to be based on wholesale cost without making it clear what the basis will be for determining wholesale cost. Can this be left up to the Assistant Secretary without further policy guidance? Should not the reimbursement for multiple source products be limited to the maximum allowable cost (MAC) set by the Health Care Financing Administration?

At the present time we do not have definitive recommendations specifically related to mothers and children, but we would be pleased to examine the issues if the committee wishes us to do so.

In conclusion, Mr. Chairman, we want to thank you for the opportunity to testify on the National Health Insurance for Mothers and Children Act (H.R. 1702). We believe the hearings on this bill will bring children back to the top of the health policy agenda in 1978.

Mr. SCHEUER. Thank you very much, Dr. Lee.

Several of the witnesses have talked about health education efforts. As you recall, we even passed a health education bill a few years ago, but nothing very much seems to have happened. Why is this? Is it because we really don't know how to move from the general to the specific and set up workable action programs? Are there some workable health education programs that have escaped our attention that could provide models for legislation?

Dr. LEE. Part of it has been in the past when the President's Commission on Prevention issued their report, they reviewed some, I think, 1,000 articles in the literature on health education and they found only 8 in which there was any evaluation demonstrating a positive outcome. We know, however, from the studies that Dr. Bergman mentioned that were carried out by Jack Farguhar, a cardiologist at Stanford, and Nathan MacCuby, a communications professor, that it is possible through mass education, through mass media, to influence health related behaviors. They showed significant changes in behavior relating to cardiovascular risk factors. When television alone was used, and particularly when television was used with additional mass media, billboard advertisting and counseling, group counseling, individual counseling on diet, smoking, those are the principal ones that are affected.

Mr. SCHEUER. Exercise.

Dr. LEE. Exercise, I don't think, was a major concern of theirs in that particular program. I don't recall the data on exercise. They had Spanish-speaking populations in several of the communities that were relatively large. The people were concerned that they couldn't be reached in the same way. They were reached, I think, as effectively as the others. Of course they had programs in Spanish, they had publications in Spanish so that they could be reached.

Mr. SCHEUER. How recently did they publish their findings?

Dr. LEE. They have been published within the last few years. It was a very large-scale study and I think they have now been funded for some additional longer-term studies. We also know from studies of the National Lung Association on education of kids in elementary school about cigarette smoking that they can learn the facts very early, like the third grade and before. As a matter of fact, the studies that have been done in the last few years indicate that we really have to reach the kids at kindergarten through the third grade. By the time they are teenagers it is too late. There is too much peer pressure, there are too many other pressures on them to start smoking. They can learn about the harmful effects of smoking for themselves. They haven't been followed long enough to know whether this will influence their smoking behavior as teenagers.

We know that there has been a significant increase in smoking particularly among teenage girls. We know that among adults, particularly among physicians, there has been a tremendous decrease in smoking. Only about 20 percent of the physicans in this country now smoke. Interestingly enough almost 40 percent of the nurses still smoke, which tells you something about the kinds of pressures, the kind of peer pressure, the kind of social pressure and the changes in attitude. Also the statistics on lung cancer haven't really come home to

the women yet. Those behavior changes in the doctors and in the adult male population, there have been millions of adults who have quit smoking in America despite the pressures to continue to smoke, are in part related to an awareness of the specific health issues.

I think that we have a lot of evidence about the effectiveness, selected programs. The programs have to be targeted. The highest priority ought to be cigarette smoking and it ought to be in programs in elementary school. This ought to be the No. 1 priority. Unless the individual realizes that it affects them, the cigarette smoke will affect them, they will not change their behavior. If they have sort of a general idea that it is bad for people, it doesn't affect their individual behaviors.

The second priority should be in nutrition education. Again, with our massive school lunch programs, in some of them they have done a superb job of getting the kids to participate in the decisions about what foods will be chosen. They get a much higher level of proper nutrition in those programs when the kids participate.

Mr. SCHEUER. And when they serve the kind of food that is traditional in that particular ethnic group.

Dr. LEE. Right. Carol Foreman—who is now the Assistant Secretary of Agriculture, is superb. I think she is really determined to see those programs turned around and use as a means of proper nutrition, as well as a means of subsidizing our farmers and agribusiness in terms of the purchase of those products.

Those would be the priority areas. I would also say that in the area of exercise for kids, we have been in school after school, of course, doing away with organized sports programs, even because they are too costly. I think the health consequences of that are just not recognized. I would say those are three areas. I think that around the school is a place where we can do a good deal of that. They have to be provided additional resources to do it. They are hard pressed to do their job.

Mr. SCHEUER. In reading, writing and arithmetic.

Dr. LEE. Right, and we ask them to do these additional things. I think they can be done. I think they can be done with great health benefits.

When Chuck Lewis testifies this afternoon, I think that you can see directly from one who is involved with school age kids how it can be done and the extent in which kids can participate in making the decisions about what can be done and how it can be done.

I think there are tremendous opportunities in that regard. I think that the administration's failure to properly organize programs in health education, to fund them adequately, is like the failures in family planning, the failures in immunization programs, the failures to provide incentives for community fluoridation programs. All are things that we know need to be done and are not being done.

Mr. SCHEUER. And they are all in the preventive health area. We are spending billions of dollars for all kinds of sophisticated systems like CAT scanners and training all kinds of specialists for very esoteric problems that affect a fraction of 1 percent of the population.

Dr. LEE. There was a dramatic illustration last night on that 3-hour television program you missed because you were doing your homework

that showed the Mount Bayou Health Center in Mississippi. In the early days, they had a major program in sanitation. They were digging wells, they were putting in privies, they were conducting community nutrition education programs. All of those programs are now unfunded. They are continuing to fund remedial medical care. The infant mortality has started to go up again in the area. Kids are now coming in with all kinds of preventable diseases because of the failure of the Government—the people living there cannot pay for that themselves, they are too poor. We have neglected those things and we now see families without running water in their homes, without toilets, without even privies. We forget that people in the United States live under those conditions and there are a lot of them. We must have those kinds of programs that accompany any kind of program of medical care.

Just like Dr. Bergman's experiences in Seattle with fluoridation. There has been a dramatic effect on dental health.

Mr. SCHEUER. Would this bill be an appropriate structure for any of these programs?

Dr. LEE. Well, I think the things the bill does, it really provides the means for the Congress to address these issues in a way that nothing else does at the present time. And, then, decide whether in this bill you should really make it omnibus bill for maternal and child health, almost as the 1935 Social Security Act which created title V and which created the crippled children's program and maternal and child health programs and has been the vehicle for the promotion of maternal and child health in this country, the principal vehicle of public promotion of maternal and child health. Perhaps you should consider reviewing the title V programs with these provisions to make sure that there is a proper integration of maternal and child health programs, well-baby care as well as the crippled children. The crippled children's program has been one of the most successful Government programs, except it has not been adequately funded in recent years.

I think it would be actually a very worthwhile idea to reexamine title V at the same time you reexamine the issues relating to this particular legislation.

Maybe the others would like to comment on that too.

Mr. SCHEUER. Are Dr. Bergman and Dr. Robinson still here?

Why don't you join Dr. Lee and Dr. Budetti?

Do you have anything to add to what Dr. Lee has said?

Dr. BUDETTI. I would like to reemphasize the point about stimulating primary care practitioners to deliver care. I agree with Dr. Robinson that if the programs are structured properly, pediatricians are going to participate. As a pediatrician myself, I know that that is true. We can attest to that. As you know pediatricians tend to be more progressive, they tend to be more willing to institute progressive programs with nurse practitioners, nonphysicians, practitioners of various kinds. They are supporting recertification in high numbers, although there is some controversy over that. There is a lot of movement within pediatrics in favor of programs for children. If the kinks are out of the program, you are likely to have a much higher level of participation by pediatricians than you might in other physician categories.

Mr. SCHEUER. Dr. Bergman, Dr. Robinson.

Dr. BERGMAN. Well, I don't know whether or not you were responsible for stacking the witness list. I mean, we haven't talked with each other before, but there is a fairly unanimous agreement of people who are concerned with child health.

You can talk to anybody in the child health field and we are all grateful that some attention is being paid to the subject. All of us have emphasized the preventive approach. We have all talked about the problems of discontinuance of programs. I am glad Saul mentioned the onerous paperwork. Every once in a while they send a Bureau of the Budget person out to the Northwest and they bring him around to our neighborhood health center and we have to show how much money it costs just to fill out reports. We are funded by 10 different sources of public funds, each one requiring a separate type of report. We have to pay for that sort of thing.

As Saul mentioned, the individual practitioner is very willing oftentimes to take care of low-income families, but he doesn't have the time it takes to fill out the pieces of paper and it is just overwhelming. He gets discouraged by it.

I don't know what every happened to the Government Commission on Paperwork.

Dr. LEE. They issued a 900-page report.

I think that is a very, very important problem. Two of my brothers are in private practice. They happen to be in a group so they are spared some of the paperwork or as much of the paperwork coming directly to them as an individual in a solo practice. It is appalling the amount of paperwork associated with Government medical care programs.

As Dr. Robinson pointed out, the slow payment is another burden for the doctor and you are really asking those providing care for poor people to front-end the cost of their care for periods of 6 months or more. Everybody says doctors earn a good income and all that, but a lot of pediatricians don't earn that much money. They are the lowest income-earning physicians. They have the lowest hourly earnings any way you compute it. The kinds of services they provide or will continue to provide are not the kind of high-technology services. Even internists now, with the electrocardiogram, gastroscope, the bronchoscope and various things, we are getting into the sort of semisurgical business. Pediatricians are not into that. They are into things that do not generate a lot of income. When they are then burdened with these additional problems, it becomes extradordinarily burdensome to provide care for the kids who need it the most.

Dr. ROBINSON. I think we ought to make Dr. Lee an honorary member of the Academy of Pediatrics.

I agree in general with what has been said. I think that the concept the bill, aside from the written and oral testimony, the concept of preventive care in there, reimbursement for preventive care, are guidelines to the type of medicine that we would like to see. That is the concept in prediatrics of prevention. You have it all the way through the bill. No one will take issue with that aspect.

We cannot get the physical intermediaries, we cannot get Blue Cross or Blue Shield or any of the others to pay for this type of care. The only threat that they will have is if a governmental agency turns

around and says we will pay for it, I think we will have a strong argument in favor of having them incorporated, which is about to happen, I hope. The preventive care aspects are what we are interested in.

Mr. SCHEUER. How can we document the point that preventive care is terribly cost effective and that a little bit of money spent early on in a child's life is going to prevent very serious problems later on, that a little bit of money spent early on in preventive health care is going to save enormous amounts of money and very sophisticated and costly sickness care later on down the road.

Dr. BERGMAN. You have to use some graphic examples. I think the swine flu fiasco, which your committee is still wrestling with, is really a good case in point. We have known that the immunization levels in children are dropping and dropping. This is in direct correlation with the amount of money put into the Federal Vaccination Assistance Act. In recent years the money has been cut back, so we are getting decreasing levels of immunity for diseases like polio and measles and diphtheria.

I am absolutely certain and my colleagues in infectious diseases are absolutely certain that we are going to see a resurgence of poliomyelitis. There is no doubt that we are going to see it again. Yet nothing really is done. The Secretary and the Assistant Secretary keep issuing statements about how concerned they are with child health and even the President says he is going to do something about children. Yet here is one small tangible item. To hell with their speeches and press conferences. Let them just tackle one thing—vaccination assistance.

What will happen is we will wait until we have some polio epidemics and then they will come rushing and we will get into the indemnity problems and all of that. Currently, in our clinics with poor children in order to use vaccination assistance funds or use the vaccine, we have to give people a two-page consent form that they have to fill out and it scares the hell out of them. You know, all the horrible things that are going to happen to you, this sort of thing, and anyone in their right mind would look at it and say, God, I don't want that stuff.

Dr. ROBINSON. Mr. Scheuer, we have living examples. We can get you a ticket to the Orient and take you into the hospitals there. Of course I must go along. Go to Singapore, go to Hang Kong, go to China, mainland China, and you will see thousands, not hundreds, but thousands of children who are ill with illnesses that do not occur in our children. Residents and interns and medical students have never seen these illnesses. Our level of preventive care is high indeed despite all the gruesome figures that have been quoted.

You can go to Thailand and you will see a clinic there with several hundred children with acute rheumatic fever, of which there are about one or two cases per year in the city of San Francisco, and so few cases all due to prevention. They have so many that they can't hospitalize them all.

Mr. SCHEUER. What is the preventive care that will prevent acute rheumatic fever?

Dr. ROBINSON. The adequate treatment of streptococcal sore throat.

Diphtheria. I am one of the few people in the room that remembers diphtheria at its worst. You can imagine how old I am. Phil was a student of mine.

Dr. LEE. I was indeed.

Dr. ROBINSON. You go there and you see a whole ward up there and it says diphtheria with myocarditis, diphtheria without myocarditis. You go to Hong Kong and you see a whole ward full of a disease that we haven't seen in this country in years, but was present in World War I, and that is tetanus. They have a ward full of infants with tetanus because the mothers have not been educated to use a clean piece of string instead of a dirty piece of bamboo from the fields to tie off the umbilical cord in their home deliveries.

You don't have to go very far to get your models. Just go to countries that are not as enlightened in preventive care as this country is. Even that, as Abe Bergman says, is not sufficient. We have an opportunity to prevent illnesses.

We have the opportunity to prevent polio, measles, chicken pox, and, most of all, diphtheria, tetanus and so on, if we only do simple little measures in an appropriate way.

Mr. SCHEUER. Is Dr. Delmer Pascoe here?

What I would like to have you do is join this group, Dr. Pascoe, and let you testify now.

The rest of you stay where you are.

We have been told that you have been involved with the Children's Lobby here in California. As a politician, I suppose I have a great deal to learn from you. We are looking forward to hearing from you. Why don't you give your testimony now?

STATEMENT OF DELMER J. PASCOE, M.D.

Dr. PASCOE. I have the same trouble with paperwork as has been mentioned.

Dr. ROBINSON. Mr. Chairman, may I help in the introduction of this distinguished gentleman?

Mr. SCHEUER. Please do.

Dr. ROBINSON. He is a professor of pediatrics and chairman of the ambulatory care for pediatrics, but he is also a vice president of the child health disability program in the State of California, appointed by the Governor. He is also an ex-chairman of the Hospital Care Committee of the Academy of Pediatrics and one of the outstanding proponents of child health care in California.

Mr. SCHEUER. The five gentlemen who have testified here this morning are a great testament to the deep concern that the medical profession has in the whole area of child health and maternal health. Again, I want to pay tribute to Dr. Budetti and Dr. Lee for having assembled this tremendously impressive panel.

With that, Dr. Pascoe, why don't you give us your thoughts?

Dr. PASCOE. I will give you random thoughts, if I may, and some of them will be in response to the things which have been said.

First, I would like to say that I also appreciate the highlighting of child health. It is an issue that has been too long put back and we haven't really seen it highlighted. I would add that politically I hope that something in terms of catastrophic coverage is considered at the same time. I think that makes it so much more feasible.

Mr. SCHEUER. I think, as a practical political matter, if this concept of a health program for mothers and children moves ahead and be-

comes a third building block in a program of national health insurance, following medicare and medicaid, we will undoubtedly accompany that with some kind of catastrophic program, perhaps with a fairly high threshold. We have got to do something for middle-class Americans to eliminate the devastating effects of these serious degenerative diseases.

Dr. PASCOE. You asked why there had been so little support generated, and I would take issue with what was a casual remark that this is a child-centered society and suggest that part of our difficulty has been that we really haven't done this.

Mr. SCHEUER. We say it is.

Dr. PASCOE. That is right. One only has to go back to some of those early White House conferences in 1929 and the Children's Charter and see how dismal we have been in the 50 years in terms of doing any of the things which we said were things which children had coming to them because they were children in our society. We are just a long way from having accomplished that.

Robinson mentioned the mental health. One has to only go back about 10 years ago to the Commission that looked at mental health in children and said it was a national disgrace. If we don't have our act together in terms of what to do now, that is an even larger disgrace. Ten years ago it was pointed out that we are in a terrible situation with no program for a condition which affects many of our children and for which we really have no provisions.

I worked at a large county hospital and we are just now in the process of doing the seventh floor of that hospital with mental health services. There may be something like $3 to $3½ million, of mental health money going into that hospital.

One-half salary is going into children's services. Mental health people will tell us over and over again that they have enough to do to take care of the adult population, which are so very easily seen, and those which may not have some of the preventive aspects that we see in terms of children. It is sad to look back at the 1929 charter and look at the recommendations of the Mental Health Commission and realize how little we have accomplished in terms of that.

I am a pediatrician and I am a doctor in a county hospital and I try to provide services around the clock to people who find it difficult in terms of access and who are poor and who need health education and always with too little to do what needs to be done, but we attempt to do that.

A number of years ago after the 1970 White House Conference I was one of the founders of the California Children's Lobby. As their health chairman, I was responsible for sitting down with Assemblyman Willie Brown and Steve Thompson, his administrative assistant, to put on our law books what is called the child health disability program. I do hope the committee has an opportunity to look at that as a possible kind of structure for delivering the services that we are talking about to children.

Mr. SCHEUER. I think the record should show at this point that Dr. Phil Lee is nodding enthusiastically.

Dr. LEE. And there will be a panel tomorrow.

Dr. PASCOE. A program which essentially in terms of public and private sector makes an effort to see that the question is really asked of local political areas in California, the county, are you able to provide health services for all the children in your county. The original bill came out of a feeling that there are children who go through childhood without having medical services. There are children who enter school without having any kind of an appraisal as to whether they have deficits which may make a major difference in the large task of going to school.

Mr. SCHEUER. What do you mean by deficit?

Dr. PASCOE. Hearing, vision, heart disease, orthopedic problems, as the most specific of those. That program recognized, but yet it is hard to get funds for them, the very significant need for public health education and the real significant need for outreach. There are families that you have to really almost go to the door and knock on the door to get the services to them. It is difficult to find someone who wishes to pay for that kind of an effort. That is a hard one to do.

Mr. SCHEUER. But that is not so expensive. It can be community based. It can be almost totally a paraprofessional program. You are not talking about salaries that get up near six figures.

Dr. PASCOE. Well, you talk to the board of supervisors in San Francisco and you talk about physicians you need to support a health service and they want to know if anybody is going to die if you don't get a certain kind of service.

Unless you can concretely do it in terms of the things that Dr. Robinson mentioned, neonatal tetanus, a child with diphtheritic myocarditis, you find it very difficult to get the support that you need for those kinds of services.

Mr. SCHEUER. What is neonatal tetanus?

Dr. PASCOE. An infant with neonatal tetanus.

Two years ago before the fall of Vietnam, I spent some time teaching in Saigon. I can testify to some of the things that have been said here. There was a ward with tetanus primarily of infants, a ward with measles, a ward with children limping from polio. Incidentally, some of the vaccines were available there and a mechanism for giving those vaccines was not available.

Mr. SCHEUER. I suppose you could say that vaccines are available in this country, too, that the vials are sitting in the refrigerator somewhere, but many children are not immunized.

Dr. PASCOE. Yes.

Dr. LEE. Just a comment on the outreach and the People's Republic of China where they accord a very high priority to family planning. They go out to every home if the person doesn't come in every month to get their pills. That is a priority. In terms of the wealth of that country compared to the United States, there is just absolutely no comparison. It is just they have a different priority on prevention and the provision of preventive service as an outreach is very much a part of that. I completely agree with you, Delmer, to try and sell that notion politically, to get funds at the local level to develop those kinds of outreach preventive services, you simply cannot get the funds.

Dr. PASCOE. We spent 4 hours yesterday trying to get the placement for an overdosed adolescent who was suicidal. Nobody called. Mental

health services are being provided, they are provided in Abe's clinic and in Dr. Robinson's office and in my clinic, but there is no way to charge for that 4 hours of time. If you send them to the Mental Health Services clinics, the local psychiatric hospital, they will just as likely turn around and send them on out because a bed isn't available or an intake worker doesn't think they need hospitalization, the chance for a crisis is past, the overdose is recovered from and the adolescent is out in the community again having the same kind of stresses, the same kinds of problems that were there before. It is very difficult to sell those kinds of services. Health education is very difficult to sell. I think most of us try to make it a part of what we do in the medical transaction, but there are a lot who don't have that opportunity.

Mr. SCHEUER. Considering the time pressures doctors are under, doctors who are the most highly paid professionals we have in this country, it is not feasible to expect doctors to spend very much of their time on health education? If we are really serious about it and realistic about it, we can't rely on doctors to do it and we ought to provide some kind of paraprofessional outreach.

Dr. PASCOE. They ought not to be let off the hook. They have got to do it. It is one of the most important things that they do. Certainly we have the school framework. I think Maxine will be talking and making some comments about California's plan in health education.

I would kind of like to close on another historical note. I am interested in what we have done to children. My grandfather worked in the mines 12 hours a day, 6 days a week as a Cornish tin miner and it took a long time for people to say that that wasn't proper for a 10-year-old boy to be doing. We were about to do some child health insurance in the country about 1915, as I recall, and it all got derailed, but automobile insurance, making sure that private property got taken care of, just sailed right along. That became very universal and we hardly have any cars now that aren't covered in case there is something catastrophic. The other day I creased a guy's fender, bumper, and it was $225. That is all covered. But illness in terms of our children is not something that we have been able to accomplish.

I applaud your efforts to highlight this and also would be very happy to be of any help that I can.

Mr. SCHEUER. You are very kind. Thank you very much, Dr. Pascoe.

Dr. Robinson.

Dr. ROBINSON. Mr. Scheuer, I would like to ask you a question. You have asked a few. You can take the most remarkable program and have Congress pass it, then when it gets to be implemented down at the local level, it becomes a butchery. Now, in the early pediatric screening diagnosis and treatment program, if one reads it, and I happen to have done as much reading on it and studying on that as anything I have done, it is a superb program. I think Congress should be congratulated for extending on the medicaid program an outreach program, inclusion of dental services, vision services and auditory services, just as Dr. Pascoe said the deficiencies were. Yet, when it got down to the States, and particularly to the county, it became a screening, an inadequate screening program, as some of the people in this room will tell you. If you pass a bill such as H.R. 1702 with all of the ideal things in it that Dr. Bergman and Dr. Lee and Dr. Budetti and Dr. Pascoe have so far mentioned, you still have the

problem of bureaucracy. I think that needs to be solved before any program is passed by Congress.

Mr. SCHEUER. I hope you are wrong because I doubt if we are ever going to solve that program. Unfortunately under our tripartite system of government we elected officials pass legislation, but we don't have a chance also to administer the laws that we pass. The history of Congress is replete with dedicated Members of the House and the Senate who are really concerned and involved and knowledgeable, and they work to pass needed legislation. But along the line, as it is administered, the drive and the concern and the momentum seem to be lost. What happens in the field is pretty inadequate.

Dr. BERGMAN. I have always imagined being Secretary of HEW for a day. In my dream I would fire half the people in the Agency according to a table of random numbers. Then I would come back a year later and I would be pretty sure that the productivity would be the same or perhaps even better. That is the agency I am the most familiar with. I am sure the Commerce Department and Interior Department and all those are worse. I don't know. I think there are so many people who have created their own empire in themselves and they don't have the degree of commitment for carrying out the job.

Dr. LEE. Mr. Chairman, I would like to say a word on behalf of the bureaucracy, having served as the Acting Secretary for 1 day. During the almost 4 years that I was in HEW, I was associated with the ablest people that I have ever been associated with in my life.

Those are people not only like John Gardner and Wilbur Cohen, Bob Ball in Social Security; Bill Stewart, the Surgeon General; Jim Shannon, the Director of NIH; Art Lesser in the Children's Bureau. You can run through a very, very long list of very, very competent people. Art Hess and Bob Ball when they put medicare together did it from absolutely scratch, a phenomenal management accomplishment.

No other organization could have done that, I don't think. I don't think there was any group in the private sector that could.

Dr. BERGMAN. The problem there is the people in Washington, D.C., once they cross the Potomac River, they seem to think that they become imbued with a certain knowledge. A great column was in the "New Republic" during the summer, a guest column of TRB, called The Macho of Time. It said in Washington people tell you how hard they work, the President gets up at 6 in the morning and works hard. There was a story about some guy who works 16 or 17 hours a day in the White House. All these people are telling you about how hard they work. We still have poverty and disease and all these problems. What are the results at all this work these people are doing? I wish they would perhaps put in less time and maybe do a little more thinking.

Dr. LEE. One of the things that I think does show is the complexity of the problems that we are dealing with. These are not simple problems and we can bemoan the paperwork, which I certainly share your annoyance with, as much as anyone, but these are complicated problems and the problem is how do you administer a program. How do you put the medicare and medicaid programs together which were enacted by the Congress separately? We have multiple categorical programs enacted by the Congress and not by the departments that try to administer them.

To try to integrate those is very difficult. I think the integration of this program with existing medicare and medicaid programs, plus a catastrophic provision will require careful planning. I know that Professor Ted Marmor, has written about that, I am sure Wilbur Cohen has talked to you about it. I think that to combine those two things together may be a sound idea, but it requires more consideration. It is complicated. I think one of the things that needs to be addressed perhaps in subsequent hearings is much more detailed consideration of how is the program going to be administered, what is going to happen, so that in the writing of the law we can avoid some of the mistakes that have been made in the past.

Some of the problems now with medicare, for example, are quite clear. People are operated on in nonhospital surgery centers (surgicenters) at one-third the cost or less, one-tenth of the cost for some patients, of going to a hospital. The surgicenter isn't reimbursed by medicare because it isn't specifically in the law and they can only reimburse those institutions that are named in the law. Well, that is not HEW's fault, that is a problem that Congress has to deal with.

I think that in the course of the subsequent hearing that more attention should be paid to these problem. I think tomorrow when you talk about the screening programs and the disability prevention programs that implementation can be considered. We have seen evolve in California the way to run a program that, I think, in the experience of everyone here, is so superior to the EPSDT programs around the country that that lesson has really got to get home to the Congress, it has got to reach the people much more forceably and it has got to reach the people much more forceably in HEW.

Mr. SCHEUER. Are you speaking of the California child health disability program?

Dr. LEE. Yes.

Mr. SCHEUER. Now, maybe you and Dr. Pascoe could tell us about how that actually works and what seems to be the elements there that have made it work.

Dr. PASCOE. It is a complex story. I can give you just a couple of the elements. First, the responsibility for that program was put at a county level. Really the State administration was essentially to be a minor support to the county's needs as they saw them with the population that they were dealing with. We ran into immediate difficulties, though. The State wanted to assume much more responsibility for that kind of program than originally had been intended in the legislation. They wanted to collect data for the pure reason of maybe some day analyzing it and making some scientific discoveries. That isn't what we were really about in terms of the legislation.

Mr. SCHEUER. Isn't that part of the oversight and the evaluation?

Dr. PASCOE. But it is one of the tendencies, I think, in any kind of a program for somebody to try to make more out of it. What we are looking for is child health services and we really ought to concentrate in terms of the services.

I know for a while in California there was an effort to use the program to set standards of care. That is important, but that is not what that program was really for. Complex things needed to be made much less complex. There were county directors and county programs and county advisory that attempted to do a program on the basis of what

their needs were in that county getting support from Sacramento rather than the kinds of directions we don't like to plan, you have to resubmit it, redo it, this kind of an effort. It was an attempt from the very beginning to see that we had as many of the health care providers involved and it was a strong effort to have private and public sectors realize that that was probably the only way that would ever work.

Dr. LEE. Mr. Chairman, I hope you will excuse me, but I have to leave to make a presentation this noon. I just want to say that I appreciate the opportunity to have testified. I want to thank you and the staff for the superb job that you have done, and also for putting kids back into the national agenda again. I think it is a critically important action. We really are very, very grateful to you for doing that. Thank you very much.

Mr. SCHEUER. I think that is a great closing line for this morning's session.

We will recess now and we will reconvene at 2 o'clock for the afternoon witnesses.

[Whereupon, the subcommittee recessed at 12:10 p.m., to reconvene at 2 p.m.]

AFTER RECESS

[The subcommittee reconvened at 2 p.m., Hon. James H. Scheuer, presiding.]

Mr. SCHEUER. The House Subcommittee of the Interstate and Foreign Commerce Committee hearings on a national health program for mothers and children will come to order.

We're going to hear informally for the next 10 or 15 minutes from Prof. Victor Fuchs who has done some outstanding work in the economics of health care. He provided me, in a perfectly brilliant book he wrote called "Who Shall Live," and I will always be indebted to him for starting me thinking seriously on how we can produce a national health care system that produced excellent health care at a reasonable dollar cost.

So, Professor Fuchs, why don't you take over and give us of your wisdom.

STATEMENTS OF VICTOR FUCHS, PH. D., PROFESSOR, STANFORD UNIVERSITY, AND CHARLES LEWIS, M.D., PROFESSOR OF MEDICINE, UNIVERSITY OF CALIFORNIA, LOS ANGELES

Dr. FUCHS. Well, as I said when I agreed to come down and have lunch with you, I have no prepared statement to make, and I have not yet had an opportunity to read the particular bill that is under consideration here. I would rather use the few minutes that we have available now to respond to questions or to even join in a discussion with Dr. Lewis, who, I know, is scheduled to speak next.

Mr. SCHEUER. Well, Dr. Lewis, why don't you join Professor Fuchs. We're going to hear from Dr. Charles Lewis, professor of medicine at UCLA in Los Angeles, who has written and researched, extensively, in recent times on child initiated care and how young people can be given a sense of responsibility for their own health outputs.

Why don't you start out, Dr. Lewis, and then we'll see if Professor Fuchs can't intervene from time to time.

STATEMENT OF CHARLES LEWIS, M.D.

Dr. LEWIS. Let me make a couple of initial statements that Dr. Fuchs may want to respond to.

The first is, I think at the present time the last thing that we can afford is any form of national health insurance in the United States, since we can't really control the system that we have at present.

Mr. SCHEUER. What are you dignifying by the word system?

Dr. LEWIS. The thing that you're having hearings on. Essentially, a rather large industry of which I'm a part. I'm basically speaking of hospitals, medical schools, physicians, and so forth.

Eight or nine years ago, I had a colleague at Harvard, an economist named Fein—Rashi Fein—who used to suggest that the most effective way of reorganizing the health care system in the United States was to pass any bill for national health insurance, because any one of them, once passed, would so escalate the costs of care—out of sight—that we would have a financial crisis and the roof would fall in on the whole system, and the one could walk in and rearrange the pieces in whatever fashion one chose. I used to think that it was, from a physician's point of view, very cruel. I've come to see that it's probably very effective and maybe——

Dr. FUCHS. No, I think he was wrong then and I think he's wrong now.

I think that the pouring of money into the system as we have in recent years has actually made it more difficult, rather than less difficult, to get meaningful reforms, because it has caused a change in people's expectations. Particularly, it produces expectations as to how much money they should make and how hospitals should be equipped and so on.

So I'm not prepared to agree with Fein. I remember him making that argument, and I think, up until now, at least, it hasn't worked.

Dr. LEWIS. I think the question, Vic, was maybe tongue in cheek; that is, if there were no way of controlling costs and any plan that drove costs of care toward a significant proportion of the gross national product, that sooner or later somebody would say, "That's enough."

Dr. FUCHS. Well, we have——

Mr. SCHEUER. Do I understand you both to be saying that we don't know enough about controlling either health care quality or health care costs to jump full blown into a national health care program?

Dr. FUCHS. No, I haven't said that. Chuck has said that.

Dr. LEWIS. Let me back off and say that you added quality. I didn't say that we didn't know how to. I said that we had not. And there's a difference between knowing and doing.

I suspect that we know a fair amount about what should be done, and I think we have had a considerable amount of difficulty translating knowledge into behavior because of the political nature of the social system of which the health care system is a part.

Dr. FUCHS. I would go along with that theme and try to flesh it out a little bit. The fact of the matter is that there are several million people who have a very direct, important stake in the medical care system, day in and day out, year in and year out, and those are the

physicians and the people who work in the hospitals and so on, and the insurance companies and the drug companies and the manufacturers of medical equipment and so on. And then there's another 190 million or 200 million people who have an interim interest in what goes on. When they're sick, they have a very strong interest; when they're well, their interest is fairly small. I sometimes say in talks to physician groups that the average person, when he's well, thinks about his physician about as often as I think about my plumber when my toilet is working properly, and they all laugh because they've been inside, they agree that that's true.

We don't have a Nation which is hell bent for health, come what may. We have a Nation that's mostly hell bent for other things and then, when they get sick, they want a medical care system that'll patch them up.

These are kind of the kind of realistic base line datum that you have to work with when you start to create any kind of system.

Dr. LEWIS. I think my concern about the creation of further coverage by any mechanism is not only relative to the economic issues but also related to evidence that I think exists that most of these efforts tend to increase the dependency of the individual on a system, rather than foster any personal responsibility. When illness occurs, one is dependent upon a system; however, to maintain health requires on inverse set of actions.

The issue is personal responsibility for a set of behaviors. The studies that we've been engaged in for 7 or 8 years, address the origins of a set of behaviors among our patients, and how in the world these behaviors arise, since these reduce this system into a very inefficient one.

Mr. SCHEUER. Can you tell us something about your work?

Dr. LEWIS. Right. Internists who deal with adults know from individual and collective experiences that about 15 percent of the people in the United States delay in the face of illness, including significant signs of coronary heart disease, cancer—most of them are males.—About 15 percent of the individuals covered under any insurance plan, such as Kaiser or Group Health, account for over 50 percent of all visits, they call them the "worried well"—that's the least pejorative title we could give them—of those who seek care, about one-third follow medical recommendations. In other words, we have delay in the face of symptoms, overutilization for nonphysical symptoms of illness, and noncompliance in the face of medical recommendations. I'll come back to the fact that these behaviors are not related to the lack of knowledge, since if one looks at the medical profession—whose behavior in the face of illness is worse than the poor—physicians delay significantly longer than others in the face of signs of overt psychotic episodes, and cancer. Essentially this is not related to a shortage of information.

The real question is, where do these behaviors come from and what fosters these behaviors that are not efficient, regardless of how much money we put into the system?

Thanks to some observations from my wife, who cannot be here today, who stimulated the project that has been supported by the National Center for Health Services Research, we've been looking at

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the origins of health-related beliefs and behaviors in children based upon two questions: What would happen if you took all the adults out of the system for care for children, beginning at age 5; and what would be the consequences of allowing (1) children to make decisions about when they needed care and (2) to choose alternatives for their own treatment, pushing personal responsibility within the limits of medical safety?

We have studied these phenomena in Los Angeles in a university elementary school, and now in a public unified school district for the past 5 years. Let me point out first that pediatricians see more boys than girls, because mothers take children to the physician. Also, pediatric care is a transaction involving adults primarily.

And if active learning is good learning and passive learning tends to be otherwise, it might not be surprising to find that at the age of 18 most of us graduate from an adult-dominated, physician-dominated medical care system into, essentially, a world in which we delay, do not respond, et cetera.

An article that summarizes the first 4 years of this work appeared this fall—October 1977—in the Journal of Pediatrics, entitled "Child Initiated Care." With your permission, I will submit it for the record [see p. 164]. Under this system, children are allowed to take a "care card" in classroom; go directly to a nurse practitioner, be examined, be given the data base, allowed to select options for their own treatment, and get what they choose.

What this study points out is that by the age of 6, we are able to identify the same adult patterns of behavior. That is, about 15 percent of little boys do not make a visit to the nurse practitioner for 3 consecutive years. About 15 to 20 percent of children, primarily little girls, make over 60 percent of all of the visits. Most of these visits have nothing to do with health problems; these children are assuming the sick role for its benefits, since it constitutes the only legitimate escape mechanism in American society for not competing, and it is socially learned and valued very early. Thus the value of a "Kiddie Care bill," it seems to me, would not be in terms of the numbers of children immunized, but what is not quite spelled out here, emphasizing a process by which the child assumes some personal responsibility for his or her care.

We have now watched these children for 6 to 7 years. We have transplanted the project into a very disadvantaged public school system, where we again find that children can be given the responsibilities to make these decisions. What one finds is that high-user children are children under stress and that they are children who suffer from a "fractured self-concept," not a fractured arm or leg, and that the fundamental lesion in these behaviors has to do with poor decision-making, producing a consumer who is dependent upon others, a user of care without much concern for personal responsibility.

Dr. FUCHS. Dr. Lewis has been talking about some very fundamental problems and ones which may lie beyond the reach of Congress, really, to solve in any meaningful way.

I'm going to have to leave very quickly for another appointment, but I would just like to leave you with this thought. Perhaps a more sharply targeted approach than an omnibus national health insurance for children and mothers might be warranted at this point. Try to

identify two or three major problems regarding the health of children and pinpoint why they are problems. What are the obstacles? Financial? Physical access? Lack of information? If you could identify two or three key problems, identify the reasons why they are problems, and then have very sharply targeted legislation or even modification of existing legislation that addresses those particular problems, I think that would be much more productive at this stage in the development of our whole approach to health and medical care than to try to provide a comprehensive omnibus type of legislation. I am supportive of what you're trying to do in helping the health of children, but I think a more pinpointed approach would be more effective at this time.

I'm very sorry that I do have to leave.

Mr. SCHEUER. Thank you very much for coming, Professor.

Dr. LEWIS. I think that Dr. Fuchs has sort of taken my last comment, but let me go back and describe what I believe the long road looks like.

The behaviors related to health and illness in the United States are formed at a very early age, and are related to the role of children in society and type of relationship that exists between a physician and a patient, which is not a collaborative one, but tends to be "I'll treat you and if you're good, you'll do what I tell you." However, this, I think, as we realize that for patients with chronic illness, which most of us in this room have, or will have, the outcomes of care are in the hands of the patient, I think these changes are related to broad social changes, but there are some things that can be done now.

One can provide incentives, for example, to work with children in teaching decisionmaking. We've been doing research for 10 years in this field. We have just been funded to start some additional work in public schools, piloting and evaluating a curriculum which teaches decisionmaking, not information about health, but how a 5 year old can learn to make a decision. We have found in working with disadvantaged children that very few of them are aware that such options exist in the world. Also if you teach decisionmaking, it has transferability to a variety of areas; we believe most of the problems in health education are not related to a lack of knowledge, but in the affective or the nonknowledge domain.

We also must involve parents and significant others; parent-effectiveness training activities dealing with health or values that parents have for health of their children are important.

Finally, as some pediatricians have said, when we presented these studies at some national meetings, there are basic dilemmas that must be faced before pediatricians deal with children directly as very few of them do—for example, accepting telephone calls directly from a child, by seeing the child alone in their office, etc.—I have to quickly add that we're talking about the kind of illnesses that most children have on a day-to-day basis, which physicians call trivial, headaches, stomachaches, cuts, bruises, bumps. We are not talking about meningitis or leukemia or the kind of thing that most of us talk about in terms of serious pediatric illness. Pediatricians have said to us, "The reason child-initiated care will never catch on is because we can't afford it, because it takes us three times as long to talk to a child as it does to tell mothers what to do, and we're being paid on the per-capita basis." Others have said, "You know, nowhere in my medical school house-staff training did I see anybody deal with a child directly."

There are some fascinating studies related to this issue conducted by Professor Boocock, a sociologist at Rutgers, that show that when children interview children, you get different responses than when adults interview children. We have video tapes of children who take out their own splinters and visibly gain some degree of personal achievement and self-esteem. This may sound trivial, but on these grains of sand beaches are formed.

When you hear a child say, "Mrs. Lewis, I have a headache," and she goes through what's going on in class and then this child comes in 3 days later at the same time and says, "Mrs. Lewis, I have a math headache," you've just made a different kind of diagnosis, and the treatment is far different than aspirin. It is dealing with the lesion, rather than the symptom. I think our general tendency to call all things medical and once medicalizing it, or considering it in the domain of the profession and, susceptible to treatment and, some sort of categorical funding, is just going to increase this dependency.

I, like Dr. Fuchs, strongly believe—despite the fact that I am in a department of medicine and grew up as an adult-oriented practitioner—that unless one intercedes in the formation of these behaviors in childhood, and I'm talking about before the age of 5 or 6, I'm talking about day care, and I'm talking about a variety of other interventions, that we'll continue to have a very strong uphill climb to overcome noncompliance, denial, overutilization, which, aren't going to be affected one whit by any form of national health insurance that increases access.

Merely diminishing financial barriers or geographic barriers does not deal with the structural, family and interpersonal, psychological variables that I'm talking about.

In essence, what has happened everywhere else in the world, in countries, both developed and underdeveloped—and I've seen these phenomena personally in Tanzania and Denmark—is that when you reduce financial barriers, the "worried well" still are worried and still come, only more, and they're always the first in line.

Mr. SCHEUER. The worried well.

Dr. LEWIS. The worried well, in Tanzania, where the supply of medicines arrive at the first of the month, are the thick-card patients, not the thick charts patients, because they don't keep charts. The thick-card patients are well known to the rural medical aide. Physicians worldwide know those patients who are their high utilizers and know, also, that sooner or later they do get sick, not frequently with adverse reactions to interventions and so on, because eventually all of us become ill.

I guess I'm preaching a behaviorial sermon about an economic set of incentives.

Mr. SCHEUER. Describe the economic incentives that will diminish the frivilous use of the system and whatever the techniques were by which you got children to take responsibility for their own behavior.

Dr. LEWIS. First of all, I have to emphasize that, for those of us who are engaged in research on the workings of health services, it's very difficult to respond to most questions within what is the usual half-life of a political person, because we're talking about programs that may require 5, 10, 15 years for payoff.

No one is going to solve in 2–3 years the problems that I'm describing. If you want to build a pert chart describing a series of activities

it will run 15–20 years. If you provide incentives for individuals to provide care directly to children within the safe boundaries, that'll accomplish certain things. If you want to provide incentives for health education, that is not teaching children what the left ventricle of the heart does or what gonorrhea organisms look like, but about decision-making as it relates to a broader series of things, and the skills that are required, I think one can reinforce these behaviors.

It's going to be extremely difficult for anyone at a governmental level to say to me, as a physician, or any of my patients, "Here are some disincentives/incentives for being good."

We might be talking, I think, about how in the world do you get health insurance premiums reduced for those with good health habits.

One of the distressing prospects is that if you look at self-care, which much of our research with adults is focused on, the only people that are really very interested in assuming increased responsibility for their own health are those who already have excellent health, or are somewhat compulsive fanatics.

Every time we go to the more disadvantaged sections of Los Angeles and try to do a study on use of self-care books or increased personal responsibility for care, it's a little bit like saying to somebody, "Have we got a great new thing. It's do-it-yourself automobile insurance." And then you hand them a hammer, and say, "The way it works is when you have an accident, you pound out your own dents; it's cheaper." We have created in our own health care systems a series of expectations and dependencies that are going to be very difficult to deal with: therefore, "back to the kids."

Mr. SCHEUER. How have you learned that we can inculcate children with some sense that their health outcomes are going to be a product of their own decisionmaking? How do you encourage them to make the right decision?

Dr. LEWIS. You encourage them to do so, but you allow them to make whatever decisions they will. This is obviously a very broad issue. Our experiences in research are not reassuring. We have published another study, looking at the extent at which children in elementary school believe health messages on television. The bottom line of that study goes something like, about 75 percent of all messages that you see on television related to health products are believed to be credible by children ages 10 to 12, even higher among those in the inner-city. And if, in fact, as Doug Smith in a New England journal article says, about 75 percent of those messages are inaccurate or misleading, we have a very powerful ubiquitous media reinforcing a whole set of behaviors about what to do when you feel bad or how do you get to be nice: what do good mothers do, et cetera, and all of these give medicine, rather than attention.

We've passed a definition of medicine in terms of the hospital a long time ago. We're talking about a social system, and when you deal with health status, I don't think you can divorce yourself from social achievement in the broadest sense. The sooner we face up to this, the better off we're going to be. Instead of trying to cure everything by some form of insurance, we should accept that this is the tail of a dog, not the dog itself.

Mr. SCHEUER. Can you give us some specifics on what these children have been helped to do, and what the health related results of that use of conduct have been?

Dr. LEWIS. This was a research study with pretesting and posttesting on annual occasions. One of the questions that you can ask children that you can't ask adults (or at least I feel sort of strange asking adults), is, "Have you ever pretended to be sick?" Children are very honest. About 40 percent of first graders will say yes, and about 60 percent of six graders.

If you also ask children, "Does the nurse at school ever do anything that you don't like?" Affirmative responses increases very markedly when you move the focus of decisionmaking from the nurse to the child. Children find being in charge of their own decisionmaking not a very comfortable proposition at least at first.

Mr. SCHEUER. Decisionmaking over what?

Dr. LEWIS. Being able to decide that, when they have a cut, they don't need to come and have the nurse wash it and the nurse put a bandaid on it but they can go directly to a first aid box in their classroom, wash their own cut and put on their own treatment. Somebody has jokingly called our health curriculum "health on the rocks" because it uses a lot of ice, which is the most marvelous therapeutic device known to man, for most trauma. Children come, get their own ice, take care of their own injuries, unless there's some reason which leads them to believe that they need adult help. Most children find that there are some things that they can do to symptomatically relieve their sore throats, like taking little sips of water and so forth.

Most of all, they receive a sense of achievement, and what we are measuring now, while we didn't start out to measure it because I saw this, quite honestly, as a health study. I didn't really see our work as a child developmental study. We have backed up, and said that by looking at the health and illness behavior of children and advocating the kind of interventions. I mentioned, the real emphasis is on enhancing a child's capacity to be the best, he or she can be. It is a child-centered intervention that essentially says, "Be the best you can to yourself," in health, as well as other things.

Teachers say these children do better in class. We're now measuring academic achievement. It's interesting that children who are "high users" of care are seldom high achievers in class. This suggests that, coupled with losing in health, these children are also losing in education. Rogers pointed out that if you look at high school kids—who these kids will be 5 years later—who are high users of health services in high school, they're those who most often drop out, who smoke and who are academic failures. I'm not saying that these are a health-related problems. I'm saying that there's a more fundamental social lesion.

Mr. SCHEUER. And how do you deal with that?

Dr. LEWIS. By trying to, I think, impress upon a child that he/she can do something about it themselves, and where family-structures exist, by pointing out to the parents that there are lots of things that they can do. When Art Ulene, filmed this experiment and played it on the Today show, his comment was, "What can you do as parents? Maybe one of the things you can do is give your children the kind of attention that they need when they're well so that they won't have to pretend to be sick to get it." It's a little bit away from financing mechanisms and health but, and also from intenal medicine.

I'm going to have to catch a plane back, so I've got to make a decision soon. What I'm saying is not new. Like most other things that Dr. Fuchs and I have been studying for a good number of years, it has been noted about 50 to 100 years ago.

The midcentury child conference on children pointed out that children ought to be involved to the maximum degree possible in all of the decisionmaking related to their health. We happen to think this will have some impact on future adults.

This is the kind of research that we're dealing with in internal medicine, but these issues are not going to be covered in national health insurances unless someone specifically says that any form of financing mechanism must also not increase the dependency of individuals on a system because that's——

Mr. SCHEUER. But increase the dependence on themselves?

Dr. LEWIS. Called increased personal responsibility, I think, which is, I think, some ways of saying increased value of self.

Mr. SCHEUER. I was the author of a drug abuse education bill along with Congressman John Brademas almost 10 years ago and an environmental education act along with Congressman Lloyd Meads of Seattle, and I've often thought since that, in terms of drug abuse and alcohol abuse and sexual abuse, what we really need for kids is a self-esteem education act. All those other problems would fall into place if we could give them a stronger sense of self, and I take it that's more or less what you're talking about.

Dr. LEWIS. Exactly. I think to avoid a lot of scientific BS, to put it bluntly, I would suggest to you a conceptual model in which the principal independent variable is self-concept or self-esteem. This is directly related to parenting styles, directly related to a batch of other things, but I believe that one cannot put bandaids on the outside of a child and make them feel better about being who they are and being competent.

Mr. SCHEUER. Well, look, I'm a Federal legislator, and I'm in the business of passing legislation. There are a lot of things in life that are beyond the reach of government, and there are even more things that are beyond the reach of the Federal Government. Can you see any role for the Congress and for the Department of Health, Education and Welfare in supporting the kind of incentives that you're talking about? If I told you that you should play God and write a two-page memorandum of the kind of legislation you would like to see coming out of Congress that would build into our health care delivery system the kind of incentives that you're talking about, what would that two-page memorandum look like?

Dr. LEWIS. I don't know, but my only response is that I'll go home and take it over to the University Elementary School and present that same question to the children, and get you two pages from them and bring it back.

Mr. SCHEUER. You're on.

Dr. LEWIS. I think they probably have more profound things to say than I do.

Mr. SCHEUER. Thank you very, very much, Dr. Lewis. Your reputation has preceded you, and now I understand why.

[Testimony resumes on p. 173.]

[The article referred to by Dr. Lewis follows:]

STATEMENT OF MICHAEL A. LeNOIR, M.D., ON BEHALF OF THE PEDIATRIC SECTION OF THE GOLDEN STATE MEDICAL SOCIETY, A DIVISION OF THE NATIONAL MEDICAL ASSOCIATION

Dr. LeNoir. I'm an assitant professsor at the Univerity of California, San Francisco, and an associate in pediatricalogy at the East Gate Children's Hospital. I'm director of the pediatricalogy clinic at San Francisco General Hospital and I have a private practice in the inner city in San Francisco and Oakland.

My testimony is given, basically, in behalf of the pediatric section of the Golden State Medical Association, an association which represents over 1,200 black physicians in the Western States and a division of the National Medical Association.

I would prefer to kind of read from the statement since it hits the points. I represent the society and this is their position [see p. 180].

We appreciate the willingness of the committee to hear our position. We believe that we can serve as a valuable resource because, first of all, we represent pediatricians who service primarily poor children in urban inner city areas, the special population as defined by the bill. These areas, not only lack adequate health care facilities and providers, but also physician advocates and health care policy and planning who have been directly responsible for their medical care.

Mr. Scheuer. Excuse me. If it's agreeable to you, we'll keep this very informal and I'll interrupt from time to time.

How do you perceive the medicaid program which was designed to serve the poor and to fill the health service needs of the inner city minority residents?

Dr. LeNoir. Well, we certainly feel that we have been, in proportion, affected by this program more than other physicians and we certainly have seen the improvement of quality health care services in our areas. We have often said that medicaid is better than no "caid" at all, and we basically still feel that way. We have seen people take advantage of community resources because they are there. We have seen people use private physicians because they have, because they, at least in some places, are available, and we have felt that, while the program is certainly not optimum, it has helped us take better care of our patients and at the same time, provided us with the opportunity to utilize diagnostic aids and facilities that may not be otherwise available to us. The county hospital concept has somewhat diminished in the State of California because of that. So that we are not completely happy with every aspect of this program, but we do feel that it was a big step forward in terms of our ability to service the special populations that we deal with.

And, second, we feel that, here, again, in proportion, we have a greater experience within the State government, utilizing the State government as a third-party provider, a system of health care delivery much like the substance of this legislation.

Third, we do not feel that the spokespeople for the established pediatric advisory councils within the American Medical Association, the American Academy of Pediatrics or the academic pediatric or public health community can adequately represent specific aspects of our position.

Our organization enthusiastically supports the intent of this legislation. We endorse the declaration of purpose. We are encouraged that the subcommittee selected a system of free choice of practitioners, and we believe that, as you seem to, that children are this Nation's greatest resource and, as such, must be guaranteed the right to adequate health care.

We support much of the bill as written, but because of the time limitation, we choose to select to comment on aspects of the bill which we find, which we disagree with or about which we have some questions.

In the terms of "Discussion on Specific Aspects of the Bill and Proposed Amendments," we'll basically skip over parts of the "General Provisions and Administration" because the major revisions in the bill have changed somewhat the board and council concept. We do think it's a workable concept if it's truly representative, and we hope that several members of the council should have some direct experience as a primary health care provider dealing with the problems of urban and rural poor children. Frequently, these children have no real advocates in systems of this type or their positions are represented by professional people whose careers involve serving on boards and councils. They have M.D.'s, Ph. D.'s, M.P.H.'s, and a long history of representing the special interest of particularly poor children, but often have lost touch with the problems of the people that they are solicited to represent.

Second, they are often, they are only advocates or representatives from established medical organizations interested in children and, in general, we feel that they sincerely attempt to represent the position of these children, but they cannot adequately represent the interest of our membership or the hundreds of thousands of children that we service.

The administration and philosophy of these organizations develops, without input, uniformly at the city, county, State and national level from working inner-city pediatricians, and if you review the administrative structures of these organizations, you will find infrequently inner-city, black, Chicano pediatricians who are among either the active membership or in the decisionmaking positions in these committees.

In terms of nature and scope of benefits, we are pleased with the range of services to be offered to children. We are encouraged by the provisions for screening programs, coupled with followup, treatment and rehabilitation, and maternal and dental services are included.

We would like to see the scope of the bill expanded to include more comprehensive mental health services, services for children with learning and developmental disabilities, and services for adolescents.

We, as practicing physicians in these inner-city areas, have begun to see, with the medicaid program and programs of that type, improvement in the overall physical health of our patients but are increasingly frustrated that programs to preserve and encourage mental ability have not kept pace.

We feel that we have seen, with nutritional services, with more availability of medical care, with more services provided by the State, an improvement in the overall health of our children, but the very

concepts that were dscussed here previously, we have not seen any programs, we haven't seen programs for these types of services keep pace.

We have seen our children categorized in areas for leaning disability without adequate evaluation. We see very poorly developed programs for servicing these children once they are identified. We see violence in our schools completely disrupt, not only the education of children who are participating, but also the education of children who would like to participate.

And you don't see the same kind of emphasis on preserving, to encourage the self-esteem, to provide identity models, to allow our children to develop in professional areas. As an example, there was an article in the New England journal about the first of December on admission variance to medical schools for particularly black physicians, and they suggested that the problem is not a problem of admitting people under admission variance, but more a problem of encouraging youngsters at the high school and junior high school level that they can do things and that they can be physicians and other professional situations.

Often when our children encounter problems, either be they medical or, let me say this, often in our communities there are not enough resources that we, as peditricians, end up having to involve ourselves in these problems of learning disability and learning skills and you have nowhere to send these children.

So we would like to see the scope of the bill broadened to include some services in our communities for the situations of this type.

We are concerned about two key aspects of the bill, centralization of policymaking decisions and apparent overemphasis on the use of institutions to take care of children.

First, our organization is concerned about the ability of centralized boards to make decisions with regard to standards, qualification and evaluation of services offered at the local level. We feel that the administrative design should invest in State and local agencies the capacity to make decisions for their communities with regard to range of services provided and funding for those services. Again, our experience here in California with the medicaid program has taught us that where these capabilities do not exist, services are inadequately administered and poorly utilized.

Second, we feel that in the bill there is an overemphasis on institutional outpatient services. As pediatricians who represent primarily the urban inner-city areas, we are uneasy about the emphasis on sections of your bill on the management of health care problems through institutions. We believe that by its very recognition of special populations, the committee is aware of the discrepancies in the administration and availability of health care delivery in our communities.

We feel that emphasis on hospital and large regional centers outside of our communities is not the only answer. The bill does not appear to adequately attempt to develop resources, public and private, within communities.

Our patients have, over the years, have become crisis oriented seeking services when illnesses are far advanced, and we suggest that at least two factors contribute: first, the lack of community health re-

sources that we just mentioned, and secondly, the lack of physicians to proivde service in these areas.

We would ask the Congressmen and the subcommittee who will see these children even if the adequate funding is available. We, as practitioners in these areas, are constantly chided by our colleagues and State agencies for the number of patients that we see, but if we do not see them, who will see them.

In areas where the Government sponsors health care for deprived populations, many physicians will not see these patients unless they are hospitalized, and pediatricians do not by choice practice in large urban, inner-city and poor rural areas unless they have cultural or ethnic similarities with those children who comprise the special population.

We are forced to see daily large numbers of children because they appear in our offices, acute or chronically ill and because, most importantly, no one else is really there to see them.

If we are to upgrade the quality of service to these children, should we not seek to establish facilities in communities and physicians in these communities so that preventive medicine, well baby care and maternal services are readily available.

Mr. SCHEUER. Dr. LeNoir, that's what this bill is all about, to establish preventive health services in the neighborhoods, in other words, to change the focus of our national health system from hospital beds in big major hospitals to a community-based essentially preventive care system.

This bill may not be the answer, but certainly that is the focus and philosophy of the bill and, hopefully, you can help us fine tune our thinking so that we can do it better.

Dr. LENOIR. We are somewhat confused in terms of the language of the legislation. Most of the qualifications or setting of standards, most of the language that is, addresses administration method of payment, it's addressed toward institutional pediatrics.

If, in fact, this is the intent of the bill, we heartily endorse this as a principal.

We are concerned very much about the resources in terms of physicians to service these children. Even if you look around a community like San Francisco and, certainly, the Oakland community, relatively sophisticated medical communities, you will find, in terms of just a specific ethnic example, one black pediatrician practicing full time in the city of San Francisco and no more than five in the whole Oakland-East Bay community.

Certainly, it's not because a good practice is not available. It just appears that only black physicians will practice in these areas in any large quantity. Certainly, other pediatricians will see these children without reservation and provide quality medicine for them with certainly an essence of dignity, but it doesn't appear that unless there is an active program to recruit physicians into these areas, that we will ever have adequate help in trying to upgrade the quality of these services.

Certainly, it's true in California where the programs of medicaid exist, that physicians will see these patients in other areas. I mean you can take a medical patient, and he can be seen all over the area.

But we have not seen the establishment of a new pediatrician in the inner city in Oakland or in San Francisco in over 5 years, or certainly 3 years, when one came to San Francisco.

So unless the legislation addresses itself to this as a problem, even with the resources available, even with the moneys available to pay for these services, we don't feel that the substance of the bill, the quality health care for which the bill was designed, would be adequately implemented in these areas.

We just have a couple of comments——

Mr. SCHEUER. You would say the medicaid program does not provide sufficient financial incentives to bring new doctors into the central core areas of this region, let us say in downtown Oakland?

Dr. LENOIR. I would certainly think that——

Mr. SCHEUER. Are the reimbursement provisions inadequate to induce doctors to practice in downtown Oakland and to serve that minority community?

Dr. LENOIR. Well, I would say there are probably three major problems with this.

First of all, I think that certainly there's no question but that those of us whose practices primarily involve third party governmental programs do not, are not as well compensated for services as pediatricians who practice in other areas. But I don't think that's the whole thing. I just don't think that by choice people establish practices in those areas with which they have very little personal cultural relationship. Certainly, a good practice is available in downtown Oakland, but in terms of what I know specifically, I think that it probably has more to do with just a relationship with those communities with a kind of a program to provide physicians to these communities so that they can develop an idea of what a practice is really like and not go on misconception.

Certainly, the military has been extremely effective with the program of this type because by the time you get through with the military-sponsored education, you owe the Army 8 years of pediatrics. By that time, that gives you a good idea as to what you would be in for if you choose to make a career of that.

So that I personally feel and most of the members of my organization feel that these incentives have to be provided at the premedical and medical school level.

Mr. SCHEUER. Let me ask, how many minority doctors have the medical schools turned out in California, let's say in the last 5 years?

Dr. LENOIR. I can't give you actual numbers.

Mr. SCHEUER. Just give me a ballpark figure.

Dr. LENOIR. Well, I really probably even couldn't do that. I know that——

Mr. SCHEUER. Is it 100 or 500 or——

Dr. LENOIR. Oh, I'm sure it's just maybe between 150 and 200.

Mr. SCHEUER. Well, if it's over 100, why haven't you had more than 1 black doctor enter pediatric practice in San Francisco region?

Dr. LENOIR. Well, first of all, pediatrics——

Mr. SCHEUER. In other words, there are black doctors who have graduated from medical school to serve that community, and apparently you say that through medicaid, an adequate reimbursement

system is there, but why has not more than one of them settled in this most marvelous region in the United States to live?

Dr. LENOIR. Well, I think, if you look at statistics on which professions are happiest and which professions are not, then I would think you'd see the pediatricians are generally regarded as the most unhappy of the medical specialists. It's not an easy specialty to go into. It's certainly not an easy specialty in the inner city where the parents are, where the medical care is not structured, the immunization schedule can be often very ragged, and it's just not a particularly attractive specialty.

Certainly, we have seen the increase in the number of black physicians through these special programs, but if you look at the statistics, in the last 5 years, the percentage of physicians in this country in terms of black physicians relative to the total number of physicians in this country has dropped from approximately 4 percent to approximately 2.7 percent.

So that while there may be more black physicians graduating from these schools in California, pediatrics is not particularly an attractive specialty, and there are probably still many, many more patients available than doctors graduating.

Mr. SCHEUER. Where do these black doctors decide to set up practice?

Dr. LENOIR. Well, I think it's still a little early to tell because these programs are programs of the last 5 years or so and we're just starting to see those graduating come out into specialties. I don't think that the first burst of minority physicians recruited under these programs who have gone into specialties has been felt in communities. It takes 4 years of medical school and usually 4 years of specialty training, and so I think the next 2 or 3 years you will start to see what impact these programs had.

But if I recall correctly, I think admission variance is just about 6 to 7 years old, and I don't think we've felt the full impact of the significance of these programs.

In terms of administration and method of payment, much has been discussed with regard to this section of the bill and we just choose to comment on two principles we feel are the most important.

Careful attention should be given to cost containment and surveillance of cost effectiveness. Our experience suggests that all too often moneys are spent unwisely for duplication of services, unnecessary diagnostics and administration.

Physicians then become the focus when too much Government money has been spent, and it's our personal feeling, having dealt with the system that the system of high cost of medical care could not exist without some self-interest on the part of the community providing these services.

Hospitals, physicians, administrators, laboratories, all these combine to contribute to the high cost of medical care.

So, when physicians are asked to see large numbers of patients because often there's no one else to see them, then their names are published in the paper as making $100,000 or $125,000 from the medicaid program, when the very laboratories that service these children may make $500,000 or $1 million. The child may get X-rays, three or four X-rays from different facilities. Academic communities fund re-

search studies. So we feel if a program of this type is set up, then a very cost-effectiveness surveillance should be a rigid portion written into this bill, frankly so that we don't always get the blame.

We find that it's true, in many areas there's little trouble in getting money for hospitalized children, but it's difficult to get adequate funding for basic preventive or simple treatments, and we feel that emphasis more appropriately placed on preventive available pediatric services will, in the long run, prove cost effective.

Second, we feel that financial inducements must be given to the physicians to practice the areas most representative of the special population of the bill. We must have help if you wish the philosophy of this legislation transferred into real and quality health care services for children.

The last section of our bill, we have some suggestions on specific recommendations since we feel it's not fair to just analyze legislation and not propose certain things which we feel might be helpful.

We feel, first, that the National Medical Association and other organizations of this type be consulted before memberships of the council are selected, members of the council. This increases the likelihood that special populations are adequately represented.

Second, we feel that State and local agencies be given real authority to make decisions with regard to distribution of services, qualification of providers, and funding.

Third, we feel that more emphasis should be placed on establishing health care facilities within communities along with encouraging the growth of quality regional health care institutions.

Fourth, we feel that an effort should be made to increase the numbers of physicians who practice pediatrics in the inner-city and rural areas. We would support a program of physician extenders, particularly nurse practitioners if such people are set into middle- upper-income areas, freeing physicians to practice in areas where they are really needed, where the children are really sick.

Finally, we would suggest that more emphasis be placed on preventive service programs such as family planning; comprehensive prenatal care; programs for adequate immunizations; programs of screening for common environmental and genetic diseases; programs designed to educate parents with regard to accident and poison prevention and management of common pediatric symptoms.

We the membership, in summary, of the Golden State Medical Association express our appreciation to the subcommittee for hearing our testimony. Those of us who practice medicine in the inner-city urban areas have become increasingly frustrated because we could only react to the impact of the legislation dictating the way we deliver services in our communities, legislation that affects us in proportion much more than other physicians who provide health care to children.

Today, for a change, you've given us the opportunity to give input as a significant program for comprehensive health care is being developed. We encourage your subcommittee to continue to solicit opinion from organizations such as ours before this bill passes into law. We can, under special circumstances, be of significant value to you in providing input which is both innovative and relevant.

[Dr. LeNoir's prepared statement follows:]

STATEMENT OF MICHAEL A. LANIER, M.D., ON BEHALF OF THE PEDIATRIC SECTION OF THE GOLDEN STATE MEDICAL SOCIETY, A DIVISION OF THE NATIONAL MEDICAL ASSOCIATION

I. INTRODUCTION:

The pediatric section of the Golden State Medical Association - a Division of the National Medical Association represents over 1200 black physicians within the western states. The organization appreciates the willingness of the subcommittee to listen to our opinion on certain aspects of the Scheuer-Javits Child Health Care Bill (H. R. 1702 and S-370). We believe that we can serve as a valuable resource of information to your committee for the following reasons.

A. We represent pediatricians who service primarily poor children in urban/inner city areas - the special population - as defined by the language of this legislation. These areas not only lack adequate health care facilities and providers, but also physician-advocates in health care policy and planning who have been directly responsible for their medical care.

B. In general, we have had in proportion a good deal of experience in dealing with the state government as a 3rd party provider over the period of the last ten years. As system of health care delivery much like that proposed by the substance of this legislation.

C. We do not feel that the spokespeople for the established pediatric advisory councils within the American Medical Association, the American Academy of Pediatrics or the academic pediatric or public health community can adequately represent specific aspects of our position.

Our organization enthusiastically supports the intent of this legislation. We endorse the declaration of purpose specifically listed within the first section of the bill. We are encouraged that the subcommittee selected a system of free choice of practioner by the patient. We believe as you seem to that children are this nations greatest resource and as such must be guaranteed the right to adequate health care. We support much of the content of the Scheuer-Javits Health Care bill - as written. But because of the time limitation, we plan to restrict our comments to structural aspects of this legislation, about which we have questions and reservations. We will conclude our discussion by proposing to the committee some changes in emphasis which we feel will be of some aid in implementing the substance of this legislation.

I. DISCUSSION ON SPECIFIC ASPECTS OF THE BILL AND PROPOSED AMENDMENTS

A. The General Provisions and Administration.

1. Composition of the Board and Council

The board and council concept for administrative purposes properly implemented, can be a very workable system, if both are truly representative. Our organization believes that at least one member of the board and, several members of the council should have had direct experience as a primary health care provider dealing with problems of the urban and rural/poor. Frequently these children have no real advocate often being represented in such positions by.

a. Professional people whose careers involve serving on boards and councils.

They have MDs, pHDs, MPHs and often, a long history of representing the special interest of particularly poor urban children. We believe that input from such people is invaluable but often they have lost touch with the problems of the special interest groups they are solicited to represent.

b. Representatives from established medical organizations interested in children.

In general, we feel that they sincerely attempt to represent the interest of all children, but they cannot adequately represent the interest of our membership or the hundreds of thousands of children we serve. The administration and philosophy of these organization develops almost uniformly at the city, county, state or national levels without input from working inner city physicians who deal with children.

Therefore, we believe that an effort should be made to make this board and council truly representative for the interest of all children.

2. The Council Chairmanship

We question the advisability of the board chairman serving as chairman of the council. We feel that this could easily come to represent conflict of interest. It has been our experience that a board tends to take a paternalistic, patronizing attitude toward a compliant council. This often reduces the impact of a dual administrative system of this type.

B. The Nature and Scope of Benefits

In general, we are pleased with the range of services to be offered to children. We are encouraged by the provisions for screening programs coupled with followup, treatment and rehabilitation. Maternal and dental services are included. We would like to see the scope of the bill expanded to

include more comprehensive mental health services; services for children with learning and developmental disabilities, and services for adolescents. We as practicing physicians in these inner city areas have begun to see improvement in the overall physical health of our patients but are increasingly frustrated that programs to perserve and encourage mental ability have not kept pace.

We are concerned about two key aspects of the bill, centralization of policy decisions and, the apparent over emphasis on the use of institutions to take care of children.

1. Centralization of policy making decision.

Our organization is concerned about the ability of a centralized board to make decisions with regard to standards, qualification and evaluation of services offered at the local level. We feel that the administrative design should invest, in state and local agencies the capacity to make decisions for their communities with regard to range of service provided and funding for those services. Again our experience has taught us that where these capabilities do not exist, services are inadequately administered and poorly utilized.

2. Emphasis on Institutional Outpatient Services

As pediatrician who represent primarily the urban/inner city areas we are uneasy about the emphasis of sections of your bill on the management of health care problems through institutions. We believe that by its very recognition of special populations, the committee is aware of the discrepancies in the administration and, availability of health care delivery in our communities. We feel that emphasis on hospital and large regional centers outside of our communities is not the only answer. The bill does not attempt to develop resources, public and private within communities. Our patients have, over the year become crises oriented seeking services when illnesses are far advanced.

We suggest that at least two factors contribute to this situation.

a. The lack of community health resources we previously mentioned.

b. The lack of physicians to provide service in these areas.

Who will see these children even when adequate funding is available. We as practioner in these areas are constantly chided by colleagues and state agencies for the numbers of patients we see, but, if we do not see them, who will. In areas where the government sponsors health care for deprived populations.

(1) Many physicians will not see these patients unless they are hospitalized.

(2) [illegible]ticians do not by choice practice in large inner city and [illegible]or rural areas unless they have cultural or ethnic [illegible]milarities with those children who comprise the [illegible]ecial population.

We are forced to see daily, large numbers of children, because they appear in our offices, acute or chronically ill and because, most importantly no one else is there to see them.

If we are to upgrade the quality of service to these children should not we seek to establish facilities and physicians in these communities, so that preventive medicine, well baby care and maternal services are readily available.

C. Administration and Method of Payment

Much has been discussed with regard to this section of the bill. We choose to discuss two of the principles we feel are most important.

A. Careful attention should be given to cost containment and surveillance of cost/effectiveness. Again our experience suggest that all too often, monies are spent unwisely for duplication of services, unnecessary diagnostics and administration. Physicians then become the focus when too much money has been spent. Our experience has been similar to others. There is little trouble in getting money for the hospitalized child but it is very difficult to get adequate funding for basic preventive or simple treatment services. We feel that emphasis more appropriately placed in preventive available pediatric services will in the long run prove cost effective.

B. We must provide financial inducement to physicians to practice the areas most representative of your special population. We must have help if you wish the philosophy of this legislation transferred in to real and quality health care for the children in our areas.

III. SECTION ON SPECIFIC RECOMMENDATIONS

Having analyzed some aspects of this legislation, we would propose the following recommendation for your consideration.

A. That the National Medical Association and other organizations of this type be consulted before the membership of the board and council is selected. This increases the likelihood that special populations are adequately represented.

B. That one board member be selected from the council as its representative to the board and not the reverse as proposed.

C. That state and local agencies be given real authority to more decisions with regard to distribution of services, qualification of providers and funding.

D. That more emphasis be placed on establishing health care facilities within communities along with encouraging the growth of quality regional health care institutions.

E. That an effort be made to increase the numbers of physician who practice pediatrics in inner city/rural areas. We would support a program of physician extenders particularly nurse practioners if such people are sent into middle/upper income areas, freeing physicians to practice in areas where they are really needed.

F. That more emphasis be placed on preventive service programs such as

1. Family planning
2. Comprehensive prenatal care
3. Programs for adequate immunizations
4. Programs of screening for common environmental and genetic diseases
5. Programs designed to educate parents with regard to accident and poison prevention and management of common pediatric symptoms.

IV. SUMMARY:

We the membership of the Pediatric Section of the Golden State Medical Society express our appreciation to the subcommittee for hearing our testimony. Those of us who practice medicine in the inner city urban areas have become increasingly frustrated because we could only react to the impact of the legislation dictating the way we deliver services in our communities. Legislation that affects us in proportion much more than other physicians who provide health care to children.

Today for a change you have given us the opportunity to give input as a significant program for comprehensive health care is being developed. We encourage your subcommittee to continue to solicit opinion from organizations such as ours before this bill passes into law. We can under special circumstance be of significant value to you in providing input which is both innovate and relevant.

Mr. SCHEUER. Well, you've already done that in a very significant measure.

I'm still a little bit uncertain as to what kind of incentives you feel physicians need to go into these central core areas? Apparently, the current system and whatever reimbursements exist, haven't been able to attract either black or white doctors.

Dr. LENOIR. Well, we feel that most black doctors who practice, practice in these areas, and so that really has never become a problem.

Mr. SCHEUER. Now, wait a minute. If you've got between 100 and 200 black doctors who have graduated from your medical schools in the last few years and you've only got one additional doctor in the pediatric community in this city, doesn't that lead to the inference that they're not practicing in the inner-city areas?

Dr. LENOIR. You mean the inference that——

Mr. SCHEUER. These several hundred black doctors who have been added to the pool of doctors are not opting to serve low-income areas.

Dr. LENOIR. My people are human too, and we feel that those incentives probably, the same problems that discourage all physicians from practicing in some of these areas sometimes discourage black physicians. But if you find black physicians in practice, you'll find that very few of them practice in nonblack, urban, inner city or rural poor areas, and I don't necessarily think this is by choice. It's just a reality that to build a good practice, it's difficult to establish that kind of practice in Marin County or in some of the other areas where you may find more lucrative compensation.

I don't feel that doctors generally are any more altruistic than anybody else, and I think that, in fact, in point of reality, the incentives would probably have to be financial, in terms of scholarships. It has been done in the military. The military provides comprehensive educational support for any number of physicians and from the first year of medical school on and then they are obligated then for 8 years.

I have seen written programs that were designed to provide these same kinds of incentives at that level.

I don't think offering a doctor more money, necessarily, will keep him practicing in the inner-city area, and, in fact, I don't think we want doctors of that type necessarily in inner-city areas.

We do feel that if doctors at least establish practices in these areas that they will discover that the patients are of the same quality as patients anywhere and that they will not, the delusions that exist about practicing in urban areas would somewhat disappear, and we feel that a lot of good practices would be established; but I think that, in reality, financial incentives probably at the medical school level with obligations to physicians to practice in areas where they're needed will probably be optimum.

Mr. SCHEUER. We do have a National Health Service Corp that does provide scholarships to medical schools for doctors who will commit themselves to serve in inner-core areas or in rural areas. Do you have any of these doctors?

Dr. LENOIR. Not many. Not many doctors have opted for that particular program.

Mr. SCHEUER. Now, why is that? Because they don't want to be committed to practicing in the central-core area?

Dr. LENOIR. Well, I think that's probably an accurate statement. I think that they, there's a lot of, I think there's a lot of misrepresentation of what a practice in these areas is like.

The other part of the problem is that always there's a hassle in terms of the third-party payment because most of our patients, if you break down the structure of our practices, our medicare and medicaid patients, and there are a lot of forms, there's often a lot of harassment, there's often refusal to pay for certain basic services, and I think a lot of physicians just get fed up.

In terms of pediatrics, I think that probably pediatrics is the least attractive of all the medical specialties generally, and I think, while the American Academy of Pediatrics has made an effort to improve that image, perhaps we, as physicians in these areas, have not kept pace, and perhaps we should take some of the initiative in trying to recruit physicians into these areas.

Buy yet and still, poor rural areas are still underrepresentative, that nonblack and mostly medicare patients in this country are not urban, inner-city black children.

So that I think that if you review the percentage, the numbers of doctors providing health care in these areas, you will find that something must be done if we're to get these children taken care of.

Mr. SCHEUER. What do you think that something is? We've tried the incentive at the medical school level. That doesn't seem to be working very well for your area.

So you have resentment on the part of young doctors-to-be, that you're asking them to give up several years of their life in a practice, either a rural area or an urban-core area, that they do not consider very attractive. So you have opposition from the very groups that you're trying to encourage.

Dr. LENOIR. I'm not suggesting that this program be specifically designed to support black medical students, but that area of this country where pediatricians, particularly, are underrepresented be mapped out and programs be made available whereby students can get financing if they sign obligations to these areas.

Mr. SCHEUER. What I am saying is that, as you say, these areas would seem on their face to be satisfying to young black doctors; they should be, but young black doctors don't seem any more interested or committed to serving in these center-core areas than any other kind of doctor. I agree with you that they're motivated——

Dr. LENOIR. Well, I don't think young black, first of all, I don't think we felt the impact of that program, but, second, I think you can count the number of young black doctors who are in practice who are not practicing in these areas, it's just a reality of practice, that is——

Mr. SCHEUER. Well, I don't understand the numbers. If that's true, you have several hundred graduates of the medical schools who are black, where are they practicing if they're not in the central-core areas?

Dr. LENOIR. Like I said, I don't think we've begun to see the impact of these admission variance programs yet, in specialties, particularly pediatrics. I think that, like I say, these are programs that are 6 years old. It takes 4 years of medical school, 1 year of

internship, and, most often, 3 years of residency, and, in fact, in the residency programs, we are starting to see doctors who are interested in practicing in inner-city areas. But up until recently, we have not had enough black doctors to serve any area where there are large numbers of black patients, so, consequently, the slack has to be taken, if we want to distribute the quality of services to all these children, then the slack has to be taken up from the pool of available doctors, not just the pool of available black or Chicano doctors, but the pool of available doctors.

I can't understand why the military can be very successful in recruiting these doctors who have to serve then an 8-year obligation now, as opposed to maybe 2 years when I was in the military and perhaps——

Mr. SCHEUER. I can tell you as a Congressman, I would hate to count the number of cases where doctors have come to my office who work in hospitals in my community who now are being called up for their military service and who want to be relieved of their obligation.

Dr. LENOIR. Well, when I was involved in the training program, and this is just in the last couple of years, there were 23 applicants for the 4 pediatric positions we had, all coming from people who were on this national health service scholarship, and so that I think the Berry plan is a little different. I mean that's a whole different program, but I think this health service scholarship has been extremely successful in recruiting doctors for the military, so much so that there are probably three applicants for every one residency position in the service, and that obligation is over 8 years. By the time you get through doing the residency and intership and complete the obligations that they require, you have an 8-year obligation to the military.

Now, there must be something about the substance of those incentives that are different from that of the National Services Corps, and I think possibly that should be reviewed, and then I think that would help us to develop a corps of resource people.

We were optimistic, at least I think the American public was optimistic, that physician extenders and nurse practitioners would be their answer. First of all, nurse practitioners are probably less valuable in circumstances of practices in inner city where children tend to be more acutely ill and decisions have to be made more often by physicians. Second, the studies have shown repeatedly that nurse practitioners and physician extenders choose to practice where everybody else chooses to practice, in urban areas and middle-class and upper-income areas where the remuneration is proportionately greater.

So that I think, if you look at the programs that are available where these scholarships have been successful in staffing places, I think the public health hospitals in certain of these areas are well staffed, and certainly the military has got an influx of physicians and I think that maybe you should analyze these programs to see what kind of incentives they have. I think the next couple of years will then give us some idea as to what impact admission variance has on staffing, on providing people in inner city, urban, rural areas with specific ethnic designations with positions.

Mr. SCHEUER. Thank you very, very much. Your testimony is very thoughtful and very provocative.

That will complete the hearing for this afternoon, and we will convene for the second and last day of hearings tomorrow morning in this room at 9:30.

Thank you all very much for attending.

[Whereupon, at 3:20 p.m., the hearing adjourned, to reconvene at 9:30 a.m., Thursday, January 5, 1978.]

MATERNAL AND CHILD HEALTH CARE ACT—1977

THURSDAY, JANUARY 5, 1978

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
San Francisco, Calif.

The subcommittee met, pursuant to notice at 9:30 a.m., room 13154, Federal Building, Hon. James H. Scheuer, presiding [Hon. Paul G. Rogers, Chairman].

Mr. SCHEUER. The second day of the hearing of the Health Subcommittee of the Interstate and Foreign Commerce Committee will now commence.

We are happy to welcome Lester Breslow, dean of the School of Public Health of the University of California, at Los Angeles.

We are very happy to have you here with us, Dr. Breslow. Do you have a prepared statement?

Dr. BRESLOW. Yes, sir, I do. I am submitting it to you.

Mr. SCHEUER. All right. It will be printed in its entirety, in the record [see p. 208]; and so you can simply talk to us, and perhaps we'll have some questions for you.

STATEMENT OF LESTER BRESLOW, M.D., M.P.H., DEAN, SCHOOL OF PUBLIC HEALTH, UNIVERSITY OF CALIFORNIA, LOS ANGELES

Dr. BRESLOW. Fine.

I am very pleased to have this opportunity. I would emphasize that while I am the dean of the School of Public Health of UCLA, I am speaking today as an individual. I am sure that you do not need any iteration on my part of the need for the kind of a program that you are proposing, so I would like to jump directly into my first significant statement.

Mr. SCHEUER. Well, we have a hearing today to inform me and also to create a record for the other 250 million Americans who aren't here. Perhaps it would be worthwhile if you would tell us your perception of whatever need you feel there is for such a program.

Dr. BRESLOW. I believe that there is a serious need. The proposal responds to the fact that the health of children, and their mothers, in this country is by no means as good as it should be. In 1968, in an opportunity that I had to address the American Academy of Pediatrics, I quoted the president of the previous year of that academy, Dr. Hughes, who said, in regard to the need of children:

> My daily evidence is the children who have not seen a physician in more than a year, have received no immunizations and appear at our hospitals in the late

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stages of severe preventable diseases or bear a handicap that should have been corrected years ago. In the much larger cities, the situation is far worse. We do have a serious health problem in the children of Americans and only the most sheltered of physicians would deny it.

I wish I could tell you, Mr. Scheuer, that in the 10 years since those remarks were made, America has overcome the conditions described; unfortunately, essentially that situation is still with us.

It should be noted, of course, that ready access to good medical care would not solve all the problems in maternal and child health. Housing, nutrition, education, and other factors are also important. But health supervision by qualified personnel, adequate immunizations, and prompt detection and correction of developmental and other defects certainly would enhance the health of children and their mothers.

The proposal that you have advanced, H.R. 1702, should be considered, however, in the context of the move toward national health insurance for the entire population. The problem is: What kind of coverage and how to achieve it. One step has already been taken, namely: Medicare. Another program to make medical care available to Americans in need, including mothers and children, is medicaid. That's welfare, not insurance. That program has proved to be such a travesty that it, obviously, must be transformed into a far more effective program.

In the next move to national health——

Mr. SCHEUER. Excuse me. What do you mean by "travesty"?

Dr. BRESLOW. I mean that there is such unevenness throughout the country, because the States have the ultimate responsibility in determining the level of the program, that the basic principle of medicaid, namely establishing equity among the children in the country in regard to access of medical care, has not been met. The fact is that States like yours, New York, mine, California, have used up proportionately vastly more of the money, than other States where the need is greater, simply because our States have more money to begin with. So, in that respect, it is a travesty.

Second, medicaid has done nothing—in fact, in California, and I believe in some other States, it has not improved the quality of medical care. Medicaid has detracted from the quality of medical care in that it has encouraged kinds of medical care which are not up to the standard which America can provide and should provide for its children and its mothers. A great deal more could be said on that subject, but that is the essence of what I mean by travesty.

Mr. SCHEUER. OK.

Dr. BRESLOW. In the next move to national health insurance, we should try to learn from experience with medicare and medicaid and not repeat the same mistakes. I would like to mention just a few of these, to emphasize them.

National health insurance, based on the social security system, does not cause devastation to medical care—as was predicted by some when medicare was passed. Separate medical care for the poor, in each State, even when well-financed by Federal and State taxes, does not overcome inequities and bad quality service—as was generally anticipated when medicaid was passed.

Merely pumping money into the medical care system, without specification of quality service and incentive for organizational efficiency, does not accomplish the desired result.

Use of private carriers for paying those who provide care, based upon the carriers' experience and natural incentive to "just pay the bills" along with those of their commercial accounts, does not yield an efficient system of reimbursement—as documented in numerous Federal reports.

Accepting the private health insurance model, in particular, not paying for preventive services, reinforces a principal defect in the Nation's medical care system. That model does not lead to prevention and health maintenance as a major thrust for medical care.

Finally, I would emphasize that careful monitoring of the program, which has not characterized medicaid and medicare, could be helpful in detecting deficiencies and opening paths to prompt correction when that is necessary.

In the next move to national health insurance, these and other lessons from the medicare-medicaid experience should be taken into account. Unless we manage to get out of the rut in which we are now kept by powerful forces—and we should admit that—medical care cost inflation will continue, inequities will prevail, and failure to achieve the full potential benefit will continue.

Now, it may be helpful to list some principles. These are the ones that I would advance, to guide the development of national health insurance in this country, and then to test programs and proposals against these principles. There are five:

(1) Eligibility of all persons in the country for the services provided, that is, universal coverage.

(2) Specifications to insure quality in the service provided, not just payment for "any" services.

(3) Emphasis on and payment for preventive rather than just the traditionally insured services.

(4) Financing on an equitable basis, using social security and general revenue tax sources.

(5) Finally, strong incentives to achieve efficiency, with consideration of both cost control and quality.

National health insurance should be judged by the extent to which it embodies these principles. For example, medicare first brought all the elderly into eligibility but was completely silent on the rest of the population; "just paid" for services, essentially without attention to their quality other than legality in the States and "voluntary" efforts; "went along with" the private health insurance model, in not paying for preventive services; was financed by a combination of social security and general tax revenues; and did essentially nothing about efficiency in medical care delivery or improving reimbursement mechanisms.

You can look at the so-called catastrophic health insurance in the light of these five principles. Its effect would be not as good as and, in many respects, much worse than that of medicare. In fact, it would be "catastrophic" to medical care in America. It would, in effect, mostly encourage expenditure to prolong death, not life. It would do so by adding a new huge payment mechanism, specifically for services whose

chief result, typically, would be to prolong death a few hours or days, through use of expensive technology. The incentive to providers of medical care would be mainly to add a relatively short but expensive period of discomfort to death. I say, mainly; obviously, there are people who do exhaust their resources in paying for care of serious, chronic illness; and they need relief from that cost burden. That relief could be and should be accomplished by another type of health insurance: One that would create incentives not to extend death but rather to encourage medical care for life, including life with burdensome illness.

Mr. SCHEUER. You talk about "castastrophic coverage"—you are describing catastrophic insurance for elderly people with serious degenerative diseases, right?

Dr. BRESLOW. Yes.

Mr. SCHEUER. There are other catastrophic episodes or incidents that hit a family. I got polio when I was 28, which was 29 years ago, and the cost impact on my family would have absolutely devastated the average middle-income family, much less a poor family.

What do you have to say about catastrophic illnesses that are nonfatal for others than the elderly?

Dr. BRESLOW. Well, I have put that in the bottom part of the paragraph on page 8 of my testimony, Mr. Scheuer. I do say there are people who exhaust their resources in paying for care of serious chronic illness, such as polio, and who need relief from the cost burden, as many families, as you point out, would need help. That relief, however, could be and should be accomplished by health insurance which is much broader in coverage, that does not focus on the expensive, essentially useless and often painful types of care which would be encouraged by the current proposals for so-called catastrophic health insurance.

Mr. SCHEUER. What you are saying is that we shouldn't have a catastrophic insurance plan as a further limited implemental step toward a national health program. What you are saying is, we need a national health program.

Dr. BRESLOW. Correct, and to the extent that you would have a so-called catastrophic health insurance program, that would pump money into paying expensive technological bills which do not really extend life very much. Without——

Mr. SCHEUER. You are talking about elderly people, now. You are not talking about young children or middle aged people.

Dr. BRESLOW. The vast amount of the dollars that are actually spent on so-called catastrophic illness goes to older people. Now, it is true, and I would emphasize that I agree with you thoroughly, that families with young children—or people of any age—need relief from that cost burden.

Mr. SCHEUER. Right.

Dr. BRESLOW. All I am saying is that the natural incentive of the current proposals would be to add and extend days, perhaps hours or weeks, of discomfort to death.

Mr. SCHEUER. I really feel very deeply about what you are talking about, Doctor.

Dr. BRESLOW. Mr. Scheuer, I'm really very sorry that you have had that particular experience. What you have described is all too

common nowadays. My point is that the so-called catastrophic health insurance approach would do nothing to minimize what you described. As a matter of fact, it would add every incentive to doing exactly what happened in that case.

Turning now to your own bill, H.R. 1702, to bring it more fully into accord with the five principles that I have advanced for national health insurance in this testimony, I would suggest attention to several changes, I should say that, in preparing this testimony, sir, I had a copy of the bill as introduced in January of 1977, together with the statement of major revisions. Obviously, there was more behind them, than was in that brief statement. I'm not protesting. I just want to indicate that there may be a limitation in my testimony that, in part, may have arisen from that circumstance.

First, I would suggest a clear statement of commitment on the part of Congress to establish a unified system of national health insurance that would provide for comprehensive medical care service to all persons in the country. Without such a clear commitment, H.R. 1702 would likely become just another fragment, like medicare and medicaid, each doing some good but in a different way, to a different population, not designed to become a part of a truly unified national system.

Mr. SCHEUER. Dr. Breslow, you talked about the abuses under the medicaid and medicare system and they are manifold, and I offered a piece of legislation to get at the problem of fraud and abuse. Let's assume there weren't any physical or financial deterrents. Let's assume that our coffers were bulging. Do you think that we are ready to go to a national health care system? You talked about the lack of monitoring, surveillance, and the assurance of quality health care. You talked about the duplication and the overuse. You alluded to what we commonly call the "family ganging," without using the words—total absence of a rational system, with all kinds of overuse and abuse. Do you think we know enough now to jump full grown into a national health care system without freezing into concrete all these abuses that you very properly and very aptly referred to?

Would you consider that a loaded question?

Dr. BRESLOW. No; but it is a complicated question. I'm sure you will agree with me that it is a complicated question.

Mr. SCHEUER. Yes.

Dr. BRESLOW. I think it is a very good question, as a matter of fact, I would say, in a very crude and general answer, "Yes; I believe we are ready." We do have the knowledge and resources to proceed into national health insurance for all of the people of the country.

Mr. SCHEUER. Assuming we had the resources, do you think we know enough about quality control to cost control?

Dr. BRESLOW. Yes; I believe we do. We know enough about those things. We have not yet put them into effect, so that I would want to see a national health insurance bill—even what could become a very substantial step toward it, such as H.R. 1702, to incorporate provisions for cost and quality control, for incentives to efficiency, built into the health insurance program.

You used the phrase, in introducing the question, "national health care system"; I'm not sure that we are ready for a national health

care system. I think the country is overready for a national health insurance system—an insurance system that would take advantage of the pluralism, some of it good, in our system.

Mr. SCHEUER. Yes.

Dr. BRESLOW. I'm not seeking one fixed scheme of how medical care should be delivered, but I do believe that we have sufficient knowledge to put the money we now spend through a federally controlled health insurance system. There is no more money involved. One of the greatest myths in the whole debate is the notion that we are talking about adding billions or hundreds of billions of dollars to our national budget. The money is already there, It is being spent and being spent, to a great extent, wastefully. The issue is how to get control of that money——

Mr. SCHEUER. Now, wait a minute, Dr. Breslow. You talked to great length about the fact that we are not providing adequate health care to our children and our mothers. The statistics are pretty clear. Half of the children, by age 16, have never seen a dentist. Now, don't you think that, if we had a health care system whereby all of our children, age 16, have seen a dentist—saw a dentist once a year, after age 2 of 3, that would cost more?

Dr. BRESLOW. I believe that——

Mr. SCHEUER. I'm not saying we shouldn't do it. In fact, I feel very strongly that we should do it, but if instead of serving half of the kids with varying degrees of dental care, we served all the kids with good dental care—I can't believe that it wouldn't cost more. I think that, from the long-term point of view, there would be such improvements to health and we could avoid some long-term preventable diseases and sicknesses, that ultimately there might not be an additional cost; but certainly, in the short-run, while you are rendering the services, before you have had the benefit of the avoidance of future illnesses, in adult years, certainly wouldn't there be a short-run, an increase in health costs for serving every American child with dental care?

Dr. BRESLOW. I believe that, if at the same time we introduced a program of the kind that you are describing and want to see, and I join you in that, at the same time we introduce a new and good set of services for people not now receiving them, we introduce adequate controls on the present waste in the health care system, there would be no greater expenditure than at present. We would have not only more equitable, but we would have better services by correcting the tremendous wastefulness of the present system.

Mr. SCHEUER. Do you think that if we would cut out the waste, the fraud, and the abuse, that we would save enough to pay for the extension of services to all major groups in our society that are not enjoying them?

Dr. BRESLOW. That's correct.

Mr. SCHEUER. Well, you may very well be right. I don't think any of us know enough to say, "Yea," or "Nay," on that one.

Dr. BRESLOW. No; let me jump ahead of my testimony, if I might quote from somebody that I don't often quote from, but I think it may be very appropriate here, on this very point.

President Nixon, I believe, did express it very well when he said in his February, 1971, Message to the Congress, in reference to medical care, and this is a quote:

> The toughest question we face, then, is not how much we should spend, but how we should spend it. It must be our goal, not merely to finance a more expensive medical system, but to organize a more efficient one.

Unfortunately, the Nixon administration did practically nothing to carry out the idea.

Mr. SCHEUER. It's good rhetoric. I'll agree to that.

Dr. BRESLOW. But it could be done. That is my point. It is not only good rhetoric, but it is feasible, considering our state of knowledge of technique of how to supervise and get control of the quality and the cost of medical care. I've indicated one point about your bill that I think is important. Second, I would propose greater specificity of provisions to insure quality in the service that is provided. It goes some of the way; for example, it would require a surgery to be performed by qualified surgeons. It would require second opinions for certain kinds of surgery.

Mr. SCHEUER. Do you believe we ought to have a second opinion by a pediatrician? We had testimony yesterday by Dr. Robinson, the head of the Academy of Pediatrics, and he wanted us to specify that the second opinion, on needed surgery, would be required from a pediatrician—can you react to that?

Dr. BRESLOW. What I have suggested and others have also suggested is that the second opinion be by a general physician, who might well be a pediatrician in the case of children. In fact, the surgery would be performed only after reference from a general physician, who might well be a pediatrician.

Mr. SCHEUER. Would you or would you not be in favor of a provision requiring that after the first recommendation for surgery, for a child, that the second, collaborating or disagreeing opinion, be by a pediatrician—that's what Dr. Robinson suggested.

Dr. BRESLOW. Well, he is, obviously, a clinical pediatrician and I am not, but I would be inclined to say that there ought to be at least one of each, namely, a referral by a general physician, who believes that the surgery should be considered or possibly undertaken, and then, of course, a surgeon making the decision. If you have a surgeon——

Mr. SCHEUER. Now, wait a minute! You're confusing me. Let's say that a child is being treated by a pediatrician and he thinks that an operation is necessary, and there has to be a second opinion. If I understood his testimony, Dr. Robinson feels that that second opinion must be by another pediatrician.

There are—one of two other alternatives: the second opinion could be by a nonpediatrician, either a general practitioner or a surgeon, or it could be any of the three. Now, do you feel that the second opinion must be by a pediatrician or that it should be by a physician other than a pediatrician?

Dr. BRESLOW. I wouldn't specify that it be any particular kind of a physician.

Mr. SCHEUER. It could be by another pediatrician?

Dr. BRESLOW. Could be.

Mr. SCHEUER. And it could be by the general practitioner.

Dr. BRESLOW. Could be by a surgeon.

Mr. SCHEUER. Or it could be by a surgeon?

Dr. BRESLOW. As far as I'm concerned.

Mr. SCHEUER. And you don't think that we ought to specify?

Dr. BRESLOW. No; I don't think that we ought to specify that in a bill. In regulations, perhaps. As we assess the situation and as the distribution of pediatricians extends throughout the country—I'm thinking of rural parts of our country where you might not find two pediatricians—I could visualize that, in the future, what Dr. Robinson suggests might be appropriate and feasible. I would simply have to question it at this time.

Mr. SCHEUER. Let's say, for metropolitan areas. In legislation you can always make a distinction—you can say where feasible, where possible, where convenient, but let's say in the metropolitan areas where it is perfectly obvious that you can get two pediatricians—do you think, as a matter of principle, that he is on the right track?

Dr. BRESLOW. Again, I would have to say—even put that way, that I'm not sure that I would agree with Dr. Robinson. I would emphasize, however, that I would not sharply disagree with what he is proposing. I would be just a little more lenient. I would answer the question, then, "No." I do not think that it is necessary to have two opinions in regard to surgery by pediatricians. I think it is necessary to have it by two physicians, but not necessarily by two pediatricians.

Mr. SCHEUER. But you wouldn't specify that the second opinion could not be a pediatrician—you would simply leave that open?

Dr. BRESLOW. That's correct. I would leave that open.

Mr. SCHEUER. OK. Let's proceed.

Dr. BRESLOW. Now, since the bill does not go far enough in specifying quality provisions, there is danger of inviting the development of "child health care mills" by individual physicians, groups of physicians, or others, or otherwise perpetuate the adverse effects of medicaid on quality.

In California, we can speak quite feeling about that issue, because we have seen encouragement to the development of so-called medical care mills, which provided services to children and mothers.

Mr. SCHEUER. Medicaid mills serve the poor?

Dr. BRESLOW. Correct.

Mr. SCHEUER. And a lot of the poor are children and mothers?

Dr. BRESLOW. That's right.

I think we must be very conscious of that experience and do what we can to avoid its perpetuation in the next step we make toward national health care.

Mr. SCHEUER. In New York, where I'm pretty familiar with the medicaid operation, I would have to tell you that there was a lot of fraud and abuse and overutilization of the system in the ways that we are all familiar with. Still, in all, there is an awful lot of medicine cranked out in ghetto areas where there was nothing before. Some of the doctors running these medicaid mills organized these things on a mass production basis, and they were making six-figure money, but when they were investigated, in most of the cases, it turned out that

they just had a very high-powered mass production operation obviously, on the part of doctors, they had very little time for individual patients, or to give preventive health counseling, but they were seeing people all day long on quite a rationalized production line basis and people were getting pretty good health care; whereas, before there was nothing. So, on a scale of from 1 to 10, you might not rank them 10, but you would probably rank them 8½. Eight-and-a-half is a heck of a lot better than zero.

Dr. BRESLOW. I agree with you. What I was referring to was the "scandals," I think that is the proper word for it, that we had in connection with the so-called prepaid health plans here in California. They were a feature of medicaid and encouraged physicians and others to organize groups to provide what I'm sure all of us would have to agree is poor quality care. I'm not against fast or efficient care—fast or efficient care, if it is of good quality. You have indicated that on a scale of 10, 8½ is not so bad.

Mr. SCHEUER. What do you feel about the prepaid plans as a model for maternal and child health?

Dr. BRESLOW. I think that the prototype prepaid plan, such as Kaiser, is an excellent model. There are other ways of doing it. I'm not saying that is the only way, but I think it is an excellent model. We have carried out studies which show that the extent to which preventative services are actually provided to people by the prototype HMO Kaiser plan is higher than that in the rest of the general medical community, in the same area. We have done that in Alameda County, Calif., and in other parts of California.

Now, unfortunately, that's the prototype only. There are some imitations—what I would call second and third generation prepaid health plans—that have departed totally from the precepts, the principles, of good group practice prepayment plans. They have just sought to make what in common parlance is a "fast buck." That is what we need to avoid, to draw that line, to enhance the original prototype, and it isn't just the Kaiser plan—there are similar plans in many parts of the country—that I think we could do well to model after.

There are other approaches to the problem. That is not the only model, but it is one, to answer your question.

Mr. SCHEUER. It's not the only way?

Dr. BRESLOW. No.

Mr. SCHEUER. It seemed to us that the prepaid model was particularly appropriate for maternal and child health, more so than for other large population groups, because preventative health care is such a large part of pediatric care—the injections, the innoculations, the examinations, the screening, the counseling the mother on good nutrition. It was because we felt that pediatricians, as a group, perhaps, had more of an open mind than other groups or practitioners, and because we felt that pediatric care and maternal care was particularly appropriate for the prepaid concept, that we built in what we hoped would be a useful demonstration of the prepaid model, building on the Kaiser experience and that of others. Do you, personally, have any feeling about the prepaid model as a model for this dispensing of health services, is an appropriate model for maternal and child health programs?

Dr. BRESLOW. I do have a strong belief on that matter and I agree with you thoroughly. Your analysis included two points. One is that the nature of the services to be provided children and pregnant women, mothers, is largely the sort that can be ideally handled as a health maintenance service on a prepaid basis. The exceptions, the deviations from the norm, which have got to be watched for and provided for, are still a minority within the system, so that the emphasis is on health maintenance.

Mr. SCHEUER. On prevention?

Dr. BRESLOW. On prevention, yes, so the nature of the service——

Mr. SCHEUER. And on health education, too?

Dr. BRESLOW. Correct, as a matter of fact, you might be interested in the paper that Ann Somers and I published a few months ago in the "New England Journal of Medicine" which specified for children of various ages and for pregnant women, as well as for persons of other ages, a package of preventative services. It included both specific procedures, like immunizations, taking the blood pressure, and the like, and as you indicate, counseling—personal health education is so important.

Mr. SCHEUER. Do you know Dr. Chuck Lewis?

Dr. BRESLOW. Very well. He's a colleague of mine at UCLA.

Mr. SCHEUER. Well, he gave us some marvelous testimony yesterday about how early on you can counsel young children and he was telling us that children of ages 5, 6, and 7 were in direct communication with doctors and were helping decide on their own treatment modalities. That was an eyeopener for me. But when you look at the fact that we will soon be spending $180 billion a year for health, I don't see any answer for it other than apart from getting people to understand that their health outcomes are their own business and their own responsibility, and that they have got to organize themselves and their own behavior in terms of ingestion of drugs and alcohol, and tobacco, proper nutrition, proper diet, proper exercise, avoidance of violent situations, before we are going to get a handle on health outcomes.

All the CAT scanners and the open heart surgery units in the world aren't going to do that. People must come to understand that they have to take some responsibility themselves for their own health outcomes—and if you listen to Chuck Lewis, you have to believe that that process can start and should start very early, in the preventive health model. I don't know how you could do that on a fee-for-service basis. What doctor is going to sit down and take that kind of time with a kid on a fee-for-services basis?

This is a sort of a dramatic example—what Dr. Chuck Lewis was telling us. It's an example more dramatic than I could ever conjure up in my wildest imaginings of the rightness and the appropriateness of a prepaid model, with lots of consultation and lots of health education, and lots of counseling built in. It was particularly appropriate maternal and child health.

Dr. BRESLOW. Well, I certainly agree with and admire, as you do, the work and the presentation that Chuck Lewis makes on this point.

Mr. SCHEUER. If you would give us a copy of your article in the "New England Journal of Medicine," if it isn't too long I think we would make it a part of this record and print it in the record.

Dr. BRESLOW. I'd be glad to do that for you [see p. 225].

Mr. SCHEUER. Very good. Thank you very much.

You may continue, Dr. Breslow.

Dr. BRESLOW. So I do agree that counseling and self-responsibility is an important feature of improving health. Second as you also point out, however, it is important to give attention, not just to the consciousness of the individual, but also to the organization of health care. So I believe, with you, that there should be a better model, especially for mothers and children. I think it is especially appropriate and further, I believe that pediatricains in this country and obstetricians are more inclined to think about how services should be provided in this mode than are other physicians.

Mr. SCHEUER. Why is that? I hear that from everybody so I've come to believe it.

Dr. BRESLOW. Well, there are some pediatricians and, perhaps, some obstetricians here and they might say, "Because they are better people" I don't know.

Mr. SCHEUER. Is it their medical school training or anything in that——

Dr. BRESLOW. No, my own opinion is that it is the nature of their practice. That is what they mostly do—is to guide mothers, expectant mothers, during the period when they need medical guidance. Their focus is on health maintenance. Similarly with pediatricians, the focus is on health maintenance to that infant, from the moment of birth until the child passes on into the period beyond childhood. What distinguishes the obstetricians and the pediatricians from the rest of the doctors, in my opinion, is the actual nature of their practice.

Mr. SCHEUER. They are not "crisis medicine" oriented.

Dr. BRESLOW. Correct. Now, they do take care of crises, of course, because there are such.

Mr. SCHEUER. But it's an incidental matter.

Dr. BRESLOW. Exactly. It can be incorporated into a health maintenance system. But for the adults of the country, we have what you would call a "crisis oriented" system—what I call a "complaint-response system," rather than a health maintenance system, so that we just are upside down in regard to the care of adults in the country. That is why I think you are absolutely right that you can approach this matter very readily with the kind of services and the kind of physicians that you have in pediatrics and obstetrics.

Mr. SCHEUER. Well, you cannot only approach it more [illegible] but intrinsically that's the kind of health care you are talking [illegible] when you are talking about maternal and child health care. It intrinsically is maintenance of health and preventive health and counseling. It isn't crisis oriented.

Dr. BRESLOW. Although you want to provide for that——

Mr. SCHEUER. Why, of course, there has to be provision for a crisis, but you don't expect a crisis. What you are trying to do is build health care habits that are going to last a lifetime for that little child and it, intrinsically, is preventive health—maintenance of health, health education, health counseling.

Well, this has been very helpful——

Dr. BRESLOW. I think that's one great virtue of your bill and I will come to that a little bit later, again. But let me say now in regard to

the provisions for quality, that there is, I am afraid, danger of inviting the development of what I would call child health care mills, unless there is greater attention in the bill to quality control

Mr. SCHEUER. Would you give us some specifics as to what you think we ought to put in, in terms of quality control requirements?

Dr. BRESLOW. Yes. I'd be prepared to outline those in considerable detail, if you want, in subsequent communication to you. Just to give some examples, however, I would think that you would want to provide for inpatient care of children in institutions of high quality with greater specification to quality control than is now included in your bill.

For example, a requirement for medical staffing of those institutions in such a fashion as to provide for full-time supervision of the medical care in those institutions, at least in the urban areas, by qualified personnel—I would say, in this case, pediatricians, because we have plenty of them. I would say, further, that the bill should provide, as some other national health insurance bills now provide, that physicians must have continuing education, if they are going to be included in the program. I would say that for——

Mr. SCHEUER. How far into specifics would you get on the "continuing" education requirement? What is reasonable in California might be very different than Mississippi.

Dr. BRESLOW. Correct. I would write into the bill authorization for the Secretary, with the advice of an appropriate body to write the specifics of those requirements with—and I would say careful—oversight by the Congress. Based upon reports that are really submitted on time——

Mr. SCHEUER. We have learned the necessity of that the hard way.

Dr. BRESLOW. I'm sorry. I don't mean to lecture you on congressional duties, but I would say that the history of medicare and medicaid is a terrible example to the Congress on how not to approach the issue.

Mr. SCHEUER. The ironic thing about all of the abuses in medicare and, more importantly, in medicaid, was that for the last 8 years, we've had a Republican administration that supposedly was looking after the taxpayer's dollar and could meet a payroll.

We had a Democratic Congress and we yelled and we hollered and we screamed and we begged and we pleaded for them to do something about getting the rip-offs out of the system, getting the abuse and the waste and the overuse out of the system, but this conservative Republican administration did absolutely nothing. For years and years and years, while this Democratic Congress of so-called spendthrifts were trying to get this Republican administration to think about the untold billions that were being wasted and misspent, they did nothing. To me, it was one of the ironies of a lifetime. But be that as it may, here we are and you are absolutely right.

Dr. BRESLOW. You asked about specification as to quality and a great deal can be said. If you wish, I would be glad to submit something. Let me mention one point, however——

Mr. SCHEUER. We'd not only like you to submit something further, but we would like you to submit any suggested language that you think ought to be put into the bill.

Dr. BRESLOW. Just to mention one other point—there is a famous California physician, Russell Lee, who happens to be the father of Phil Lee, who has had a great deal of experience with group practice plans, not prepayment, because his wasn't a prepayment plan.

I recall Russ Lee saying many times that there was only one thing worse than a bad physician and that's a bad group of physicians. It's a very profound statement, when we begin to consider what you and I and many others are now thinking about, namely, a more efficient organization of care for children and mothers—and, beyond that, for the entire population, group practice per capita prepaid medical care. I would, therefore, urge that there be considerable specification, even more important when you have groups than when you have individual physicians, to assure that you have adequate quality of the care, to avoid the terrible situations in southern California, during the last days of the so-called PHP program, under the previous California State administration.

Mr. SCHEUER. Would you spell that out for the record?

Dr. BRESLOW. Prepaid health plans, they were called. There were other terms—HMO—One of these so-called PHP's was providing care for over 100,000 persons, 80,000 of them prepaid, and some on an-individual-service basis patients, without a single full-time pediatrician——

Mr. SCHEUER. Unbelievable.

Dr. BRESLOW [continuing]. With some part-time pediatric support.

I emphasize the importance of incorporating provision for standards of quality. There is substantial momentum, in many parts of the country, to consolidate inpatient care of children in institutions of high quality.

That is happening in California and other parts of the country. At the same time, there is a tendency to establish certain specialty services far in excess of need, thus to induce poor quality, at great cost. Take one instance: In California, more than 20 cardiac surgery centers have been qualified to provide services for State programs—crippled children's programs. No more than half that number is necessary, considering the volume of cases requiring pediatric surgery. Examining the data from the State's own reports on this matter indicates that there were, as of 3 years ago—and I've seen no more recent evidence on the matter—8 out of 24 cardiac surgery centers that were providing services, paid for by State funds, on the average in quantity of surgery less than half of what was regarded as a minimum by the Joint Commission on Accreditation of Hospitals to maintain a standard of performance. These eight centers were providing about 80 operations, open or closed surgery of the heart, when according to the Joint Commission on Accreditation of Hospitals' standards for general hospitals, which most of these were the minimum, for just closed heart surgery was 200. It is a tremendous waste. Estimates indicate that the cost of providing care in the lowest eight, approved by the State and being used by the State, was three times as high as the highest eight.

The actual cost was three times as high as that of the eight that were performing an adequate number. As a matter of fact, the 16 that were toward the adequate side had plenty of resource to do far

more than pick up the volume that was being handled in these S centers with low performance. I make the estimate that they could have done well with half, not two-thirds. Not "got by," they would have been providing a better quality, as well as a more efficient service.

Lest you think that this is a problem unique to California, I would call your attention to the fact that the health commissioner of New York City, 1 year ago, in the New York Times, noted this identical problem in New York City. So we have——

Mr. SCHEUER. Well, we have 5,000 excess hospital beds in New York City. Now, they aren't scattered equally around. There's a small percentage in every hospital. There are whole hospitals that are operating with just a dismal inefficiency and ought to be closed down. I think that the new mayor will see that they are closed down, but so far the political problems of closing down the hospitals have been so formidable, that they have been—that it has really been impossible.

Dr. BRESLOW. Well, let me suggest, Mr. Scheuer, that, while I would look forward, as you do, to what the new mayor of New York might do, and political leaders in California might do about, not our 5,000 but 20,000 excess beds, according to the State's own plan——

Mr. SCHEUER. In this State?

Dr. BRESLOW. In this State. That's based on a very generous estimate of need, and on top of the very generous estimate of need, we have 20,000 excess beds. If you followed the Kaiser——

Mr. SCHEUER. Of course, you are talking about the State. I am just talking about the city. There may be another 5,000 beds, out of the city.

Dr. BRESLOW. In addition to what could be done, however, by the mayor of New York or the Governor of California, I would like to suggest that there is something that could be done in national health insurance bills, like your own, That is, to write in a provision that—I would say the State—would have the responsibility of working with appropriate local groups, say, the groups established under the health planning authorities, to establish an optimum plan for the inpatient care of pregnancy and of children—an optimum plan, for each State, going down to each area. We could do that. It's already been done, in effect. There is no problem with the technical aspects of the planning. It's been done. If you take the private opinions of those responsible in the medical and hospital professions, you'll find agreement that that can be done.

So I would suggest that your bill provide, not only for the enunciation of such a plan, but for the payment, after a reasonable period of time only for those inpatient services for mothers and children that are in accord with the plan and are needed. Begin with those which are most out of accord with the plan—those that are in the areas where there's the greatest excess to begin with. As you indicated in New York, it's not even—it's uneven; the same is true in California. There are certain areas where there is a great excess. That's one criteria. Another criteria would be, as suggested——

Mr. SCHEUER. Not only certain areas, but some of these 5,000 beds I am talking about include whole hospitals that ought to be closed down.

Dr. BRESLOW. Fine, I have the same thing in mind. The second criteria would be the size of the facilities, and the third criteria would be the nature of the services that are provided. You might even add a fourth, namely, the quality of the personnel that are available to provide the services in those institutions.

Using such criteria, you could then find the points at which you could begin to cut off the payment for the services. If your bill were to take that approach, it would be, in my opinion, be the greatest contribution that could be made; both to quality improvement and to cost control, in the present circumstances of medical care in this country.

Mr. SCHEUER. How would the medical profession react to such a provision?

Dr. BRESLOW. In large measure, negative, because they do not want to see——

Mr. SCHEUER. Where would the support come from?

Dr. BRESLOW. Well——

Mr. SCHEUER. There's only two of us.

Dr. BRESLOW. Sir, I call to your attention that there are a few more. I——

Mr. SCHEUER. But you see the problem——

Dr. BRESLOW. I see the problem very well, sir. I'm not a politician and so I don't pretend to tell you how politics should be carried out, but I would have to remark, because I've been involved in this to some extent in the past, that there are really powerful forces in the country, now, looking toward greater efficiency——

Mr. SCHEUER. Well, I wish some——

Dr. BRESLOW [continuing] And let me mention some of them—labor, church groups, increasingly management——

Mr. SCHEUER. But labor has been an impediment to the closing down of hospital beds in New York City.

Labor looks upon hospitals and health employment as government employment of last reso and they oppose closing down on hospitals on the ground that they are going to lose jobs. Now, of course, the number of jobs would diminish. That is part of the way they are going to save money. We could do it by attrition. It doesn't mean that we have to fire individual people and put them out of work. There are lots of ways that you can do it that will take the sting out of it. Over a period of time, there may be less people employed in the health system, although maybe not very much less. There will certainly be fewer employed in hospitals, but it may mean that many of those people can be trained for outreach jobs in the neighborhoods, working in the counseling activities you are talking about out of neighborhood health clinics. There is a lot of work that can be done on a one-to-one basis, with kids in school, so—who knows, maybe, by the time we get finished with the kind of preventive health care, that you are talking about, and we institutionalize that and the counseling and all of that—we may have more people working in the health service system and it may save us money in the long run.

Dr. BRESLOW. Well, I don't mean to argue or debate this point to a great length with you, but I mentioned labor and I had in mind, sir, not local labor concerned with memberships that work in hospitals—

obviously all labor must fight to keep jobs. But I am talking about—shall I call it, "big labor," in the United States that has a national perspective.

Mr. SCHEUER. Yes.

Dr. BRESLOW. AFL–CIO, Auto Workers, and groups of that sort that are very much interested and do have the kind of—what's that bad word? Muscle—that is needed to enact programs of the kind that you very much want to have.

Mr. SCHEUER. They seem to oppose my approach, because they say that what we need is a national health care system and anything short of that is bad.

Dr. BRESLOW. Well, I am strongly associated with labor in support of the Kennedy bill; perhaps, I should have mentioned that to you earlier. I want to make it clear that I am a supporter of the Kennedy-Corman bill.

Mr. SCHEUER. Are you aware, as a practical matter, that it's not really seen as very feasible or likely that a bill that sweeping could be enacted at the present time?

Dr. BRESLOW. I don't want to debate that now, except that I would make two responses, if I might, to you.

One is that I have been associated with so many things in my life that were impossible, impractical, not timely, and have seen them come about, that I have some hope for things that people—even careful and mindful people—say are impossible, impractical, and not feasible.

Mr. SCHEUER. I don't say that something like that might not be with us in half a decade or a decade. Finish the list of groups in our society who would support rationalizing health care.

Dr. BRESLOW. Well, I would start with labor, in the sense that I defined it. I think, increasingly, management is interested, because they are paying for it——

Mr. SCHEUER. You mean corporate management?

Dr. BRESLOW. Corporate management. That's correct, because they are paying so much for medical care, now, that they are beginning to get the notion that it would save them some money to give attention to rationalizing the system.

Further, there is an increasing segment of persons in the health care professions, including physicians, by no means a majority, still a relatively small but an important minority, that are technically qualified to help people like yourself, in the endeavor that you are undertaking here. I think they are a quite important group.

There is also a rather amorphous group of organizations like church groups, PTA's—people of that sort, the health consumers' movement in this country, which again is rather amorphous, but seems to contain some rather important, possibly significant supportive elements for the things that would be progressive in medical care.

Well, again, I disavow any——

Mr. SCHEUER. Well, I wish you and some of your colleagues could do something to stimulate more support for the whole process of rationalizing health care costs and health care quality, not just for support of my bill or this concept, but in general, support for the process of rationalizing health care. I wish you could develop more support

for that in the medical establishment. It seems to me that the AMA and the American Association of Colleges—they are the responsible, leadership of the medical fraternity—as a matter of moral obligation they should be looking at this $180 billion that we will soon be spending with some sense of responsibility and they, themselves, should feel that this industry has to look inwardly and say, "Physician heal thyself. Profession heal thyself."

It may be that the Congress is a great deal to blame and it may be that we haven't given the institutional support and the payment and funding-schemes to help them to do it. If they can point the finger at us and say, "Here's what you've got to help us find," so be it! But it seems to me that there is a real vacuum of leadership in the health establishment.

Dr. BRESLOW. Well, I would hope that in just such situations as we have this morning in this room, sir, that that kind of collaboration between elements of the medical profession, and I would count myself among them, and persons in the Congress, and I would certainly include you in that element, that want to see things done, to discuss the matter and come to an agreement on what should be done.

I take it that my role, this morning here, is to suggest to you, and I am glad to have you suggest to me things that can be done.

Mr. SCHEUER. I hope that you will be very critical of this bill and give me all of the suggestions and the criticism that you honestly feel——

Don't worry about anybody's sensibilities here. I'm here to learn and I want the bad as well as the good.

Dr. BRESLOW. I would emphasize, in summary, the provision for quality of care that the bill should contain—and I have indicated some of the specifics and will in subsequent communication give more specifics about how to assure quality; otherwise, we may just worsen the situation by this bill.

The state of medicine has been well described by Alexander Leaf, a professor of medicine at Harvard. He said that American medicine is doing—and now I quote him—"too much for too few at too great a cost with too little benefit."

It would be unfortunate to introduce a situation in which we would, instead, be doing too much for too many at too great a cost with too little benefit. That is what worries me about proposals that do not include provision for the supervision and control of the quality; as well as the cost of care.

I would say, third, to follow these principles that I elaborated earlier, an important strength in your bill is the authority to establish the frequency and content of professional services for prevention. That would permit using the growing concensus expressed in several documents and I mentioned one paper indicating what services should be made available. I think we need to survey what is going on with the initiation of health insurance programs, for example, surveys to ascertain what proportion of children in one social circumstance or one kind of medical care arrangement, HMO, or some other—have been immunized, 1 year, 3 years, after the bill takes effect—what's the real impact on the things that we are endeavoring to accomplish. So I would hope that you would incorporate into your bill such surveys, surveillance——

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Mr. SCHEUER. Oversights, surveillance, monitoring——

Dr. BRESLOW. Exactly. Strongly. Now, with regard to the principle of financing, you and I already agree it should be jointly by social security and general tax revenues.

Mr. SCHEUER. It's my feeling that it ought to be social security, so it is identifiable. For too long taxpayers have felt, "Well, I'm not paying for it. It's a free lunch, you know." Well, there are no free lunches and taxpayers are paying for it. The only difference in paying for it out of general revenues and paying for it out of social security is that when they pay for it out of social security, it hurts, because they see it and they are reminded of it every month. When you consider the absence of leadership on the part of the health establishment, and the absence—up to now—of any drive on the part of the Congress to face up to this question, then, it is basically the public that's going to demand we do something about these costs. The public is not going to do that, until they feel some pain, or until somebody catches their attention.

I think the best way of catching their attention is to remind them of it, to make them forcefully face up to the question that health insurance is expensive, and they, as taxpayers and as voters, have got to see that their elected officials produce a system that gives them the health results that they want at a price that is affordable and through a system which is reasonably cost effective. Ultimately, the people are in charge. How can you expect them to take charge and hold the feet to the fire of the public officials who are involved, unless they know what the score is?

Dr. BRESLOW. Right.

Mr. SCHEUER. And I think we've just got to get their attention and make them cognizant of what is at stake here and this is why I have come around to feeling that we had better identify the cost of public services so that the taxpayers and the voters can begin to take charge and hold their public officials accountable.

Dr. BRESLOW. I agree with that thoroughly.

Now, finally, one principle I would advocate is incorporation of substantial provision to improve medical care organization with respect both to quality and cost.

In the previous discussion, we have entered upon this aspect of the matter. I think a major defect of your bill, sir, is that it does not give attention to this matter of improving medical care organization so that you can do something about both cost and quality.

Mr. SCHEUER. Now, will you give us some specifics on that?

Dr. BRESLOW. Yes, I will.

I think that, for example, your bill should include, as it does not now—if I understand it correctly—specific incentive toward what you indicated might be a good model, not the only, but one good model; namely, group practice prepayment plans.

Mr. SCHEUER. Could you, again, give us some specifics on that? What would you like to see included? We will hold the record open for 10 days or 2 weeks, if you can give us some written recommendations and, if you have no objection, we will include them as part of the record and we will examine them very carefully.

Dr. BRESLOW. Thank you very much. I would like to do that.

In trying to confine the testimony to a brief statement, I didn't give all the detail that might have been given. I will be glad to add it.

I believe that national health insurance for mothers and children offers an excellent opportunity to advance the health care by improving the organization of medical care and I will supplement with a communication in detail about it.

Finally, I would say that, except for prospective rate setting for institutional services, the bill, as I see it at the present time, makes no improvement over medicare in respect to reimbursement mechanisms. I think that we need to establish greater government control over the payment mechanism, rather than to turn the responsibility—as we have in medicare—over to third party carriers, whose record in medicare leaves so much to be desired, according to HEW, Senate Finance, House of Representatives, and GAO reports. The bill should be amended, I believe, to establish government control of the reimbursement mechanism.

Now, I think that any national health insurance legislation, including yours, which could be regarded as the first phase—what, I am sure, in this country, we generally now agree we must have, namely, a national health insurance——

Mr. SCHEUER. Well, it is sort of the third phase, isn't it, building on medicare and medicaid?

Dr. BRESLOW. Well, if you want to build on medicaid and medicare, correct. I'm not sure that I would count medicaid as a health insurance. It is a welfare approach. But, I would say the second phase, after medicare.

I would be pleased to respond to any questions that you may have.

Mr. SCHEUER. Well, you have been very generous with your time, and I am sorry that we have kept you so long.

Dr. BRESLOW. I'm delighted to have had this chance to talk with you, sir.

Mr. SCHEUER. Your testimony has been very thoughtful and very much to the point—very creative and productive, and we appreciate it very much.

If you don't mind, we will continue to "tap your brains," from time to time.

Dr. BRESLOW. I'm very pleased to work with you.

Mr. SCHEUER. Thank you very much.

[Testimony resumes on p. 233].

[Dr. Breslow's prepared statement and attachments follow:]

Testimony Prepared for
Subcommittee on Health and the Environment
House of Representatives
by Lester Breslow, M.D., M.P.H.
San Francisco, 5 January 1978

Representative James H. Scheuer, Chairman for the hearing:

In response to the invitation by Paul G. Rogers, M.C., Chairman of the Subcommittee on Health and the Ehvironment, I am pleased to comment on health care coverage for mothers and children, particularly on H.R. 1702.

My name is Lester Breslow and I am Dean of the School of Public Health, University of California at Los Angeles (UCLA); today, however, I am speaking as an individual and not on behalf of the School or the University.

It is readily understandable why you, Mr. Scheuer, have introduced H.R. 1702 and why you have been joined by so many of your colleagues. The proposal responds to the fact that the health of children and their mothers in this country is by no means as good as it should be. The bill also responds to serious inequities in the distribution of health care to mothers and children in the United States.

In a 1968 address to the American Academy of Pediatrics, entitled Some Essentials for a National Program for Child Health, I quoted Dr. J.G. Hughes who said in his 1967 Presidential Address to the Academy:

> "I think it unnecessary to review the incontrovertible evidence that large numbers of American children are receiving little or no health supervision. This fact has been amply documented. In the Department of Pediatrics of which I am chairman, I do not need statistics to prove this point. My daily evidence is the children who have not seen a physician in more than a year, have received no immunizations, appear at our hospital in the late stages of severe preventable disease, or bear a handicap that should have been corrected years ago. In the much larger cities the situation is far worse.
>
> "We do have a serious health problem in the children of America, and only the most sheltered of physicians would deny it."

I wish I could tell you that in the 10 years since those remarks were made, America has overcome the conditions described. Unfortunately, the situation is still with us. While the U.S. infant mortality rate has declined considerably during the past decade, the decline is part of a world-wide phenomenon and America still trails several other countries in that indicator of child health. Perhaps more significant is the fact that among our people, those who are black or poor still enjoy health to a substantially lesser degree than the rest of the population.

Ready access to good medical care would not solve all the problems in maternal and child health. Housing, nutrition, education and other factors are also important. But health supervision by qualified personnel, adequate immunizations and prompt detection and correction of developmental and other defects certainly enhances the health of children and their mothers.

A proposal to provide national health insurance for children and mothers such as H.R. 1702 is, therefore, appropriate and timely.

That proposal should be considered, however, in the context of the move toward national health insurance for the entire population. The people of this country, many of their organizations, and their political leaders have recognized the need for national health insurance - for all the people, not just mothers and children. There is a growing national commitment to establish medical care coverage for the entire population.

The problem is what kind of coverage, and how to do it.

One step has already been taken, namely, national health insurance for the elderly, in the form of Medicare. That has brought needed services to millions of Americans who previously had been to a considerable extent deprived of medical care.

Another program to make medical care available to Americans in need, Medicaid, is not insurance but welfare. Medicaid, while it has

helped some people, has proved to be such a travesty that it obviously must be transformed into a far more effective program. One of its main virtues in relation to national health insurance is the present commitment of billions of general revenue tax dollars which could be switched into a well-planned program to accomplish the original purpose. We should remember that Medicaid was supported at the last moment when Medicare was being passed by those opposed to national health insurance, such as the American Medical Association.

In the next move to national health insurance, we should try to learn from experience with Medicare and Medicaid and not repeat the same mistakes. Several points deserve attention:

1. National health insurance based on the Social Security system does not cause devastation to medical care - as was predicted by some when Medicare was passed.

2. Separate medical care for the poor in each state, even well-financed by federal and State taxes, does not overcome inequities and bad quality service - as was anticipated by some when Medicaid was passed.

3. Merely pumping money into the medical care system, without specification of quality service and incentive for organizational efficiency, does not accomplish the desired result - as the Congress was led to

believe when Medicare was passed. Unnecessary services wastefully provided from Medicare as well as from other funding sources have not only fueled inflation of the medical economy but, perhaps more important, have done no good, to health.

4. Use of private carriers for paying those who provide care, based on the carriers' experience and natural incentive to "just pay the bills" along with those of their commercial accounts, does not yield an efficient system of reimbursement - as documented in numerous HEW, Senate Finance Committee and GAO reports.

5. Accepting the private health-insurance model, in particular, not paying for preventive services, reinforces a principal defect in the nation's medical care system, i.e., patch-work service. That model does not lead toward health maintenance as a major thrust for medical care.

6. Careful monitoring of the program, research on its workings, could be helpful in detecting deficiencies and opening the path to prompt corrective action when that is necessary.

The next move toward national health insurance should take into account these and other lessons from the Medicare-Medicaid experience. Unless we manage to get out of the rut in which we are now kept by powerful forces, medical care cost inflation will continue, inequities will prevail, and failure to achieve the full potential benefit of medical care for health will continue.

It may be helpful to list some principles that should guide the development of national health insurance in this country in order to attain the real benefits from it:

1. Eligibility of all persons in the country for the services provided, i.e., universal coverage.

2. Specifications to ensure quality in the services provided, i.e., not just payment for "any" services.

3. Emphasis on and payment for preventive rather than just the traditionally insured services.

4. Financing on an equitable basis, using Social Security and general revenue tax sources.

5. Strong incentives to achieve efficiency, with consideration of both cost control and quality.

While these principles may attract substantial verbal adherence, they are often violated in bills for so-called national health insurance. Perhaps even more important, these principles must be firmly implanted and held in bills that are intended to follow them. The American people evidently want good national health insurance in all probability and will credit political leaders who fight for it and will ultimately discredit those who "give in" to political expediency of the moment.

National health insurance bills should be judged by the extent to which they embody these principles. Thus, for example, Medicare (1) brought the elderly into eligibility, but was completely silent on the rest of the population; (2) "just paid" for services essentially without attention to their quality other than legality in the states and "voluntary" efforts; (3) "went along with" the private insurance model in not paying for preventive services; (4) was financed by a combination of Social Security and general tax revenues; and (5) did essentially nothing about efficiency in medical care delivery or improving reimbursement mechanisms.

Take another example, the proposal for so-called "catastrophic" health insurance. That would indeed be catastrophic to medical care in America. It would (1) provide benefits only to a relatively small segment of people who "exhaust" their other resources for paying for medical care - insurance, or out-of-pocket, or already tax-support - people who had in effect "used up" a huge deductible; (2) do nothing to ensure quality, in fact encourage excessive and therefore usually poor quality; (3) do absolutely nothing toward preventive services, in fact use up money that would be more socially and personally effective in prevention; (4) finance benefits on a seemingly equitable basis but actually require personal expenditures for the "corridor" on a quite inequitable basis favoring the well-to-do; and (5) create incentives toward even more wasteful and inefficient care than at present, i.e., incentives to "use up" the huge deductible and enter the arena of expenditures where "benefits" are provided, without adequate cost control.

So-called catastrophic health insurance would, in effect, mostly encourage expenditure to prolong death not life. It would do so by adding a new huge payment mechanism specifically for services whose chief result typically is to prolong death a few hours or days through use of expensive technology. The incentive to providers of medical care would be mainly to add a relatively short but expensive period of discomfort. I say mainly because that would be the main incentive to physicians and hospitals. Obviously there are people who exhaust their resources in paying for care of serious, chronic illness and who need relief from the cost burden. That relief could be and should be accomplished by another type of health insurance, one that would not create incentives merely to extend death, but rather would encourage medical care for life, including life with burdensome illness that requires expensive care.

Turning now specifically to H.R. 1702, I had available as a basis for comment the bill as introduced January 11, 1977, and a 6-page statement entitled Major Revisions in the Nation Health Insurance for Mothers and Children Act, Proposed Changed in the Scheuer-Javits Child Health Bill (H.R. 1702 and S. 370). In addition I had available a copy of a letter written by me to Senator Javits July 26, 1976, I believe on the same bill (at least the comments correspond to the sections of H.R. 1702). A copy of that letter is attached to this testimony because much of it is still pertinent despite the altered circumstances in 18 months and the "Major Revisions" some of which reflect the type of thinking embodied in the letter.

To bring H.R. 1702 more fully into accord with the five principles mentioned in this testimony, the following changes are suggested:

1. A clear statement of commitment on the part of Congress to establish a unified system of national health insurance that would provide for comprehensive medical care services to all persons in the country.

The Mother's and Children's Act would be undertaken as one step toward that complete system; the latter would be in effect by a specified date. Without such a clear commitment, the Mother's and Children's Act would likely become just another fragment like Medicare and Medicaid - each doing some good but in a different way to a different population segment and not designed to become part of a unified national system. Furthermore, in line with that commitment legislation should be enacted that would bring the present Medicare and Medicaid programs into greater consistency with the five principles outlined in this testimony and, hopefully, with the Mother's and Children's Act.

2. Greater specificity of provisions to ensure quality in the services provided.

Some forward steps are proposed, for example, limiting payment for surgery to that provided by qualified surgeons and requiring a "second opinion" for some types of surgery.

Unless more rigorous provisions to ensure quality are incorporated into the bill, however, there is danger of inviting the development of "child health care mills" by individual physicians, groups of physicians and others, and otherwise perpetuating the adverse effects of Medicaid on quality.

For example, the present bill includes standards for a "pediatric unit" but the statement of Major Revisions implies some possible weakening of those standards. This is most unfortunate because there is substantial momentum in many parts of the country to consolidate the in-patient care of children in institutions of high quality. At the same time there is a tendency to establish certain specialty services far in excess of need, and thus to induce poor quality at great cost. To take one instance, in California more than 20 cardiac surgery centers have been "qualified" to provide services for state programs; no more than half that number are necessary, considering the volume of cases requiring pediatric cardiac surgery. The result is that in some not enough surgery is done to maintain standards of performance, and others that are able to maintain standards of quality are not fully utilized. So the dismal spiral of excessive facilities, poor quality and higher cost continues. As presently written the bill would unfortunately encourage such situations and perhaps even hinder the present momentum toward improved quality of hospital care for children.

With respect to quality of professional services provided by individuals or groups the bill is, except with respect to surgery, essentially

silent. Thus the bill does not preclude, and might even encourage, formation of groups of physicians and other providers who could take advantage of the payment mechanism to provide "fast," ineffective and sometimes harmful services. This kind of untoward result actually occurred in connection with California's "Prepaid Health Plans" a few years ago.

Failure of the bill to deal adequately with the issue of quality is all the more unfortunate because there are plenty of well-qualified professionals and institutions to provide excellent medical care for children and mothers in this country. What is needed is genuine protection and advancement of medical care quality in a national health insurance bill. It is regrettable but true that it is now necessary to use the reimbursement mechanism to get at this problem. Without rigorous attention to quality of service in national health insurance we may just worsen the state of American medicine described by Alexander Leaf, Professor of Medicine at Harvard as doing "too much, for too few, at too great cost with too little benefit." We may instead be doing "too much, for too many, at too great cost, with too little benefit."

3. Provision to test and guide delivery of preventive services.

An important strength in the bill is authority to establish the "frequency and content" of professional services for prevention. That would permit use of the growing consensus expressed in several recent

documents as to precisely what services should be made available for prevention. The concept is now sufficiently clear that it can now be embodied in legislation such as H.R. 1702.

Preventive services for children (and for pregnant women too) could be strengthened further by provision to measure the extent to which immunizations and other services are actually received in different situations under different arrangements for medical care. For example, sample surveys could be used to ascertain what proportion of children in one social circumstance, or in one kind of medical care arrangement, have been immunized one year and three years after the bill takes effect, compared with children in other circumstances. Such information would help evaluate and guide the program for health, not just "pay the bills" that come in.

4. No changes of principle in the proposed method of financing.

Others are much more competent that I to comment on the details of the proposed financing mechanism, but the principle of equal funding from Social Security and general tax revenues is good.

5. Incorporation of substantial provisions to improve medical care organization, with respect both to quality and cost.

A major defect of the present bill is its complete ignoring of this matter. When Medicare was enacted more than a decade ago there was a

strong conviction in Congress not to "interfere with the practice of medicine." During the past decade it has become abundantly clear that it is necessary, not to "interfere with" the practice of medicine but to develop more efficient means of delivering medical care. President Nixon expressed it very well when he said in his 18 February 1971 message to Congress in reference to medical care:

> "The toughest question we face then is not how much we should spend but how we should spend it. It must be our goal not merely to finance a more expensive medical system but to organize a more efficient one...."

Unfortunately the Nixon administration did practically nothing to carry out the idea.

National health insurance for maternal and child health care offers an excellent opportunity to advance the health of mothers and children by improving the organization of their medical care. The bill now misses this opportunity completely. It perpetuates the mistakes of Medicare in that respect. To correct this important deficiency the bill should be changed to provide for the development of organized, high-quality medical services for mothers and children - for example, through group practice of physicians; and for reimbursement on a per capita basis for such services. Inducement is needed to change the system of delivering health care in order to achieve better quality and greater

economy. Experience has shown that arrangements can be made to achieve these objectives: For example, good group practice prepayment plans such as Kaiser in California operate at much greater economy than the rest of medical care in the state and at the same time provide a higher level of preventive services. Certainly no attempt should be made to force all physicians and other medical care professionals into one mold. At the same time H.R. 1702 should be amended so as to encourage greater efficiency in medical care, both for quality and economy.

Finally, except for prospective rate setting for institutional services, the bill makes no improvement over Medicare in respect to reimbursement mechanisms. Others are more competent than I in this matter but it does seem time to establish goverment control over the payment mechanism rather than to turn the responsibility over to "third-party carriers" whose record in Medicare leaves so much to be desired, according to H.E.W. Senate Finance Committee and G.A.O. reports. The bill should be amended to establish government control of the reimbursement mechanism.

In closing I should like to emphasize my belief that any national health insurance legislation should be judged on the principles outlined above. H.R. 1702 needs considerable amendment along the lines indicated to be a genuinely useful approach to the matter. It could be a significant contribution to the development of national health insurance.

I would be pleased to try to respond to any questions that you may have. Thank you.

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SCHOOL OF PUBLIC HEALTH
THE CENTER FOR HEALTH SCIENCES
LOS ANGELES, CALIFORNIA 90024

26 July 1976

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

Dear Senator Javits:

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

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

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

My comments follow:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Thank you for the opportunity to comment.

With best wishes,

Sincerely yours,

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

LB:b32

cc: Senator Alan Cranston

Mr. SCHEUER. There will be a 5-minute recess.

[Brief recess.]

Mr. SCHEUER. On the record.

We will proceed now with a panel.

We will ask Dr. George Cunningham, Dr. Henry Shinefield, and Dr. Henry Bruyn, to come up and form a panel.

I want to thank, particularly, Barbara Durand, Jane George, and Virginia Fowkes, for having consented to move their panel back for a few moments. These gentlemen all have particular time problems.

Dr. George Cunningham, chief of genetic disease section of the State department of health,

Dr. Henry Shinefield, chief of pediatrics at Kaiser-Permanente Health Plan, and

Dr. Henry Bruyn, director, child health and disability prevention; Department of Public Health of San Francisco.

Why don't you proceed, Dr. Cunningham, Dr. Shinefield, and Dr. Bruyn, making reasonably brief statements and then we'll have you interact with each other and I may ask you questions, too.

Do you all have prepared statements?

Dr. CUNNINGHAM. Yes. we all do have.

Mr. SCHEUER. Your prepared statements will be printed in their entirety, in the record. So, perhaps, you might just want to speak informally and give the gist of what your thoughts are.

Mr. SCHEUER. You will be first, Dr. Cunningham?

Dr. Cunningham.

STATEMENTS OF GEORGE C. CUNNINGHAM, M.D., PAST PRESIDENT, ASSOCIATION OF STATE AND TERRITORIAL MATERNAL AND CHILD HEALTH AND COMMUNITY CENTER DIRECTORS; HENRY SHINEFIELD, M.D., CHAIRMAN, CALIFORNIA CHILD STATE HEALTH BOARD; AND HENRY B. BRUYN, M.D., CLINICAL PROFESSOR OF PEDIATRICS AND MEDICINE, UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

Dr. CUNNINGHAM. Thank you, sir.

OK. I'd like to state, just briefly, for the record, that my name is Dr. George Cunningham. I have had 11 years experience directing the country's largest title V, social security maternal and child health program, as the maternal and child health chief for the State of California.

I've served as consultant with HEW and on committees of the American Academy of Pediatrics in the area of government health programs and have several times before had the privilege of testifying before congressional committees in this area. I am past president of the Association of State and Territorial Maternal and Child Health and CC Directors.

I am appearing today, not as a representative of the State of California but as a representative of the association that represents MCH programs throughout the country and as one who has devoted a professional lifetime to improving the health of mothers and children and whose efforts have received some recognition of his peers.

I am not going to follow the complete text of this statement, but I am really going to follow up some comments of Dr. Breslow [see p. 239].

First, I'm a graduate of UCLA and it's surprising, although there is no collusion in our testimony, how many times I agreed with the statements that were made by Dr. Breslow. I would then emphasize some of the points where I might have some disagreement with him.

One of the first points would be on the political feasibility of national health insurance, at this time. I would tend to agree with what I inferred was your opinion, that at the present time, given the physical constraints, and given the lack of uniformity of agreement on the details of funding, coverage, et cetera, that exists in the Congress, I do not feel that it is reasonable, at this time, to try to push "whole-hog" for the whole program and I would agree that this approach that you are now taking is both, politically practical and programmatically sound and I fully support this as a wedge—the opening wedge for health insurance.

While I believe—agree with Dr. Breslow, that a great deal is known technically about how to put together such a system, I have also had to deal with organized medicine, with state government, and with national organization, recognizing the tremendous forces that are going to have to be reconciled before that technical knowledge can be actually transplanted from theory into practice.

Mr. SCHEUER. You would agree that my approach is right from the politics of it and I agree that my approach is right from the technical health aspects of it.

Dr. CUNNINGHAM. I agree on both grounds.

Mr. SCHEUER. That reminds me of the story of the person who asked George Bernard Shaw how he got along so well with Louis B. Mayer, who was a very hard-fisted man who ran MGM and he said, "Well, the secret of our success is very simple. Mr. Mayer is exclusively devoted to the arts and I'm exclusively devoted to making money," so with your approval on the politics of it and my approval on the technical health aspects of it, I think we have a good partnership going there.

Dr. CUNNINGHAM. Thank you, sir. I would fully agree with what has been repeated, I'm sure, many times to this committee, that there are two elements here. One is the funding and reducing the financial barriers to health care and the other is the organized system that is going to soak up those funds and actually deliver the health care.

I think, again, we are wrestling largely with the latter—how to provide a mechanism, and I hope that I can make some constructive suggestions along that line.

You solicited from Dr. Breslow some problems with the medicaid problem and I don't know if you want to add to that, but I can give you a number of specific problems in the experience that I have had.

Mr. SCHEUER. Would you be willing to do that in writing? You can prepare that carefully. We are holding the record open for another 2 weeks and we'll include that as part of your testimony.

Dr. CUNNINGHAM. But, you know, there are definitely deficits in that area.

Mr. SCHEUER. Yes, we would like for you to document that, if you would.

Dr. CUNNINGHAM. OK. Now, again, in reading the bill, I tried, as Dr. Breslow did, to determine just how mistakes of the preceding medicaid efforts could be avoided in the legislation that is under consideration. I have made a few very specific comments about various sections as the bill now exists. I assume that the bill will—through the course of hearings—undergo further ramifications, and since I firmly believe that the nitty-gritty is really what makes the program a success—there have been many well-intended programs and I have dealt with many people who have clearly identified problems in the Congress and have attempted to solve those problems, only to see their very good efforts go down the drain through poor implementation, poor administration, in the drafting of some of the details, so I do believe that those details are important and I will be anxious to read the exact language and make, you know, very specific recommendations.

Mr. SCHEUER. Doctor, that is why you are here and we are here and you, no doubt, understood that this bill is undergoing constant changes as a result of each of these sets of hearings. You recall Dr. Breslow stating that he got a copy of the bill, plus an explanation of the changes that have been made of that bill, as a result of our prior hearings in New York or Washington.

You know, the public sometimes has the feeling that the Government is beyond it all and nobody out there is listening. Well, this is a case where somebody is listening and we are responding very directly to your comments and criticisms and we value them. We are here for them and you can be sure that a further elaboration of the bill will include many of the suggestions and criticisms that we are hearing yesterday and today.

Dr. CUNNINGHAM. Well, based on my past experience, I can say I am very favorably impressed with the kinds of questions and the interest that has been shown so far and I am very confident about the procedure.

On the question—let me make just a specific—just a few specific questions before I offer one general comment.

The question is "a second opinion for surgery." I endorse the concept of the second opinion as a kind of service which both cost-contains and improves quality. I would concur and think that the legislation should be worded in such a fashion as to say that the two opinions should include one surgical and one nonsurgical opinion.

There is a built-in conflict of interest, if you ask a surgeon—if you are going to do surgery. For example, the ear, nose and throat man makes the bulk of his money taking out tonsils and adenoids. Now, he can be the most honest man in the world, but he has got a built-in subconscious prejudice that that's an effective operation, not based on scientific fact and analysis. I, as a pediatrician, when my child had ear infections, and he went to the hospital, they said, "We are going to do a T&A," and I said, "Why are you taking out his tonsils?" to the surgeon, and he couldn't give me a good reason. I said, "The adenoids are what are blocking the ear." He had an adenoidectomy, period! They left his tonsils in. He had a much less traumatic surgical course: It was a much simpler operation, and he has had no ear infections. But, if they need to come out for medical reasons, fine, but I'd like to see a nonsurgical person, who gets no income from the operation, have an opportunity to express an opinion.

Mr. SCHEUER. Dr. Cunningham, have you ever read George Bernard Shaw's "Doctor's Dilemma"?

Dr. CUNNINGHAM. I've read it, but I've forgotten it.

Mr. SCHEUER. Well, you go back and read the prolog to the "Doctor's Dilemma," which is the most brilliant statement I have ever seen in any literature, expressing exactly the thought that you are expressing now.

Dr. CUNNINGHAM. I'd like to make some comments with regard to some of the other elements that were expressed in Dr. Breslow's testimony.

With regard to "catastrophic insurance," I fully agree that there is a tendency, both to support expensive care that frequently ends up in the patient dying anyway, or in the patient surviving in a nonproductive fashion and probably a burden to his family and to the taxpayers. I want to call attention, however, to a program which has been underutilized as a potential for solving this problem in younger individuals and that is the crippled children's program. On the crippled children's program, catastrophic surgery, like open-heart surgery, polio treatment, renal dialysis, can be performed in specially approved centers with a partial prepayment scheme that is worked out, depending upon income, but it is not a welfare program. It affects middle-income people who can't be covered in these catastrophic events and it generally results in salvaging a child who has a really significant potential. I would like to address your attention to that program, CCS, as one that ought to be supported in the interim until we are sure that such a system like this or catastrophic or some other replacement system is in existence.

With regard to the prepaid plan concept, basically, again, I support Dr. Breslow's statement. The concept is good, by providing ambulatory services, preventative services—by providing these services, they keep down the cost of expensive hospitalization. The Kaiser plan and many other plans work, primarily because they set their own rates, based on experience and based on careful costing out of what these various procedures, preventative and inpatient costs. The reason we had such a disaster in California, with the prepaid health plans, was that the rates were set by the State and the one and only concern was to save money. There was no input from the health professionals; in the health department, and the medical people about standards. I could not say to them:

"You have to have one pediatrician for every 2,000 children enrolled and you have to have one obstetrician for every so-many women in the childbearing age group. You have to average 12 visits prenatal care. You have to immunize all kids before they are 18," as a condition of State contract, because they would say, "Hell, that is going to raise the cost of our contract." There is a built-in conflict, mixing oil in water, and we've seen it in California where——

Mr. SCHEUER. And we are seeing it in New York, too.

Dr. CUNNINGHAM [continuing]. We merged as a single health agency—the medicaid fiscal people, with the public health, the medical people, the nurses, the nutritionists, and other people, and when you are talking about $1 billion program on one hand and a few hundred-thousand-dollar program on the other hand, we are a very small tail

on a very large dog. When it comes to cost containment, utilization control, we lose time and time again. This gets me back to one suggestion that I would like to make, to address the issue of: How do we establish quality control and cost control in these systems? And my recommendation is that you separate these responsibilities into separate bureaucracies, that you have a bureaucracy that is staffed with health professionals who have no fiscal incentive one way or the other, who have access to the academy of pediatrics, to the college of OBGYN, to the medical association, who deal with them on peers, who can understand the medical literature, who can analyze the medical studies, and you say to that group:

"You establish the minimum standards for adequate care, not optimum Cadillac care, but you tell us what's minimum and what's going to be required, in order to participate in this program. You tell us the cost effect of preventative measures that need to be included. You tell us where second opinions are necessary. You work up informed consent documents so the people know what is going on. You don't have to figure rates and fees. You don't have to deal with the actuarial trust fund aspects of it, but your job is in that area."

Then, there is not the built-in conflict of interest that evolves in turning down the recommendations because they are going to cost more money. We tell them we want mothers to be seen as soon as possible for early prenatal care. They say, "Hell, we don't care if they come in until the sixth month. It saves us three visits." So it is an issue, I think that could be dealt with in that way. What I would like to do—there are other issues that need to be addressed in the same vein, namely, that some of the services that are paid for under medicaid, medi-cal, and your program, are heavily concentrated on doctor related services. They are very poor mechanisms for reimbursement for the other quality services, like counseling. We want to add genetic counseling. We have qualified genetic nonphysician counselors. They cannot be reimbursed under these programs.

Mr. SCHEUER. It's wrong.

Dr. CUNNINGHAM. Nutrition is the most important thing in prenatal care and so my——

Mr. SCHEUER. I agree with you 1,000 percent, Doctor.

Dr. CUNNINGHAM [continuing]. Feeling is rather than go on a fee-for-service basis to reimburse a nutritionist on a fee-for-service, every time she counsels a mother or a genetic counselor reimbursed on a fee-for-service—to put in a separate system which will provide on a salaried basis, these people, in every institution, qualified to participate in the program.

Mr. SCHEUER. Would you give us a list of the kind of people you are talking about. I agree with you totally on that.

And will you also give us a statement of the specific abuses of the medicaid program, which you mentioned earlier.

[The information requested was not available to the subcommittee at the time of printing.]

Dr. CUNNINGHAM. Yes; I've got to make a note to remind myself. A list of services and abuses—OK. Now, I think that in your bill, there is a section which is called—it's called "D, Special Population Benefits"; and in that section, you attempt to get at some of these

nonphysical barriers—outreach, transportation, and so forth. I think those would be most difficult to get at through a national program and I think the best way to get at those problems is working again, with this same local system, that integrates the local providers into the new system the other existing Federal programs. I am saying, for example, that there is a large WIC program. We have 37 counties in California with WIC programs. They provide nutritional education——

Women, infants and children (WIC) supplemental foods—they provide nutritional education to pregnant women and they provide actual nutritional food supplements. That kind of program can be built-in on a local level. I think it is impossible for a bureaucracy in Washington to say, "We need a bus here to transport there. We need nutrition counseling in this county but we don't need it in another county."

What the Federal Government can say is:

Every State has to come up with a plan that is reviewed by the Federal Government and provides for adequate coverage of these local services and indicates where you're properly distributed, what your needs are, and how you intend to meet those needs.

Now, the last thing that I would like to mention is the single-most important point of my testimony and that is that I fully endorse this bill and, after hearing these modifications, I definitely feel it should be vigorously supported and pushed forward as an opening wedge to improving the nonsystem we have, but in the meantime, I think that we should recognize this as, admittedly, an experimental system and its strengths and weaknesses are yet to be determined. In the interim, I'm anxious that Congress continue to support the existing programs for mothers and children, the most significant of which is title V, the most effective, the Maternal and Child Health and Crippled Children's Services. I would suggest that that system might well be developed and redirected into performing this other function of standard setting, evaluation, independent monitoring of effectiveness of care, and development of new kinds of care. I'll give you some examples.

When immunoglobulin was developed, which prevented the development of Rh disease, you would have no way, through this program or through medicaid, for making sure that doctors were aware of it and that women were aware of it, and that the physicians were set up to handle it. We required blood testing of all women to determine their blood type. They were informed of their blood type and we have reduced the number of deaths from hemolytic disease from 200, down to 40. This is the kind of thing that is done outside the payment system. It didn't cost us a dime. All it says is that on a prenatal exam, you've got to get the blood type and tell the woman the type.

We were threatened with a rubella epidemic. We said all women had to be tested for rubella susceptibility. We funded six rubella laboratories in the State with our title V money and set it up so that the resources were there.

We determined, for example, amniocentesis, can prenatally diagnose retarded children. We have established 12 university based centers to do prenatal amniocentesis and we are spreading information about that kind of program. Now, we are trying to get the medicaid program,

and other programs, to reimburse for it, but they cannot set up new systems. They cannot keep up-to-date with modern advances. What I am saying is that there is a role for both.

There is a role for a well-funded, cost-contained system which uses those standards and fees to organize the system, but there is also a role for a group of professoinals who evaluate what is going on, how it's affecting the public's health, who can deal with the doctors. I as a health professional can deal with the doctors differently than the medicaid fiscal analyst who is going to set his rates. The doctor can talk to me and say we need better immunization programs or we can stop doing smallpox, which we've stopped doing, and we can say, "We agree with you and we will eliminate that as a requirement," but some—the different orientations and skills, in running the two aspects of the program, I think, demand and would benefit from a separate treatment in the legislation, and essentially that's my major point.

Mr. SCHEUER. Your remarks have been extremely helpful and to the point, Dr. Cunningham.

[Dr. Cunningham's prepared statement follows:]

STATEMENT OF GEORGE C. CUNNINGHAM, M.D., PAST PRESIDENT, ASSOCIATION OF STATE AND TERRITORIAL MATERNAL AND CHILD HEALTH AND COMMUNITY CENTERS DIRECTORS

For the record, my name is Dr. George C. Cunningham. I have had eleven years of experience directing the country's largest Title V, SSA, Maternal and Child Health program as Maternal and Child Health Chief, for the State of California. I have served as consultant to Health, Education and Welfare and on committees of the American Academy of Pediatrics in the area of government health programs and have several times had the privilege of testifying before Congressional Committees in this area. I am past president of the Association of State and Territorial MCH and CC directors. I am appearing today not as a representative of the State of California but as a representative of the Association that represents MCH programs throughout the country and as one who has devoted a-professional lifetime to improving the health of mothers and children and whose efforts have received the recognition of his peers.

I want to make clear at the outset that I fully support, on grounds of both public health program effectiveness and political practicality, this stepwise approach to a national system of appropriate health care by focusing attention on mothers and children. However, I am gravely concerned that the best of humanitarian intentions can be thwarted and can be discredited if not carefully implemented and competently interpreted and administered. The war on poverty and the EPSDT programs are classic examples of past mistakes in the regard.

Before commenting on some of the specifics of the Act, I would like to make one or two general observations about the major issues the bill seeks to address.

One of the purposes of the Act, as stated, was to establish a system of national health care benefits for mothers and children. This needs further clarification as to whether the act provides funds and authority to organize an efficient health delivery system, based on documented and changing needs or is simply a mechanism to provide funds which will entitle mothers and children to obtain services from whatever system or set of providers who are willing to accept the terms of participation.

An additional purpose of the act was to "increase access," "enhance quality" and "emphasize prevention." It is clear that providing funds increases access if funds provided are sufficient to reduce financial barriers to care. But, as our experience with Medicaid has amply demonstrated, if fees are too low and participation made administratively burdensome, providers will elect not to participate and access can be reduced. Moreover, there are many barriers to access that cannot be resolved by providing entitlements or fee for service funds. Medicaid has not enhanced quality of care and does not monitor quality of care. Both Medicaid and the experimental PSRO's, in spite of lip service to quality, have in fact

been in the main concerned with cost control and utilization control, concepts sometimes at variance with quality. Neither has done an effective job of promoting preventative care. Various attempts have been made to effectuate cost control, another purpose of the Act. It is essential that this issue be dealt with in any health care program. But frequently this is attempted by simplistic limitations which have the effect of decreasing quality or are simply circumvented in a perfectly legal fashion, often with increased total cost. On the other hand many steps can be taken which will simultaneously improve quality and decrease cost.

So in my reading of this bill, I tried to determine just how the mistakes of these preceding efforts will be avoided and how the issues of appropriate encouragement of utilization of cost effective, preventative services will be promoted, quality determined, monitored, and improved, and an efficiently planned system substituted for the fragmented and inefficient, nonsystem that we currently support with fee for service.

I would like to go through the Bill quickly, just making a few comments on sections that concern me.

TITLE I, PART B. ADMINISTRATION

I understand that the Act has been amended to replace the Maternal and Child Health Board and the National Council with an identifiable administrative unit within HEW called the Administration for National Health Insurance and an expanded 21 member Advisory Board.

Without knowledge of the details of this amendment, I cannot comment more specifically, except to say that this is a decided improvement over the original version, which would have placed excessive power in the hands of a small, politically appointed group whose real expertise and commitment could be questioned. The agency should be named the Administration for National Health Insurance for Mothers and Children. I would also like to suggest that representation on the Board include a Director of a state, Title V agency.

Regulatory and supoena powers should be retained.

Section 114.—Funds for Evaluation are essential. I agree that it is inappropriate to have the evaluation performed by the Office of Research and Statistics in SSA. The evaluation should address not only fiscal soundness and reasonable cost but changes in quantity, quality, and effectiveness of services provided. Experts from many concerned professions i.e., public health physicians, fiscal experts, public representatives should be included. Again, I need to have details before I can offer more specific suggestions.

Section 155.—Establishing an Assistant Secretary for National Health Insurance for Mothers and Children is essential to insure top level attention to development of this important program.

Section 202.—Standards for Qualified Institutions would support the concept of minimal federal standards with states free to provide higher levels of standards as we do in California. I believe that requirement E should be rewritten to provide that the care of every patient must be the responsibility of a single physician. However, this does not preclude use of consultants or appropriate delegation of care to persons supervised by and responsible to, the primary physician.

The minimum occupancy and number of deliveries should be removed from the law but the following language should be substituted: The State Title V agency in consultation with the applicable HSA shall, after appropriate investigation, establish minimum occupancy and numbers of deliveries required for qualified institutions based on determination of need, available resources, travel time, and other relevant concerns and shall include such limits in its licensing regulations. This, along with certificate of need, is essential if we are to control cost and improve services.

Section 203.—Determination of Qualified Institutions Add to Section 203(a): In determining the qualifications of an institution under Section 202, HEW agency consult persuant to this Section, with appropriate State agencies including the State Title V agency, . . . etc.

It is important that adequate, qualified field staff be available if any standards for providers are to be meaningfully monitored or enforced.

TITLE II. PART A. NATURE AND SCOPE OF BENEFITS

The scope of benefits is quite adequate. In terms of graduated approach with limited federal dollars, I would recommend that dental services and mental services be added at a later date. The proposed addition of qualified childbirth

centers should be supported but only if developed in association with a hospital. Home births are potentially dangerous and unnecessarily expensive and should be discouraged.

TITLE II. PART B.

Section 211.—I endorse the use of second opinions for elective surgery such as tonsilectomy and adenoidectomy (and would include the ritual and unnecessary circumcision) as a measure that cost contains and improves quality.

Section 217.—I endorse the change to remove the ten day limit on drugs.

TITLE II. PART C. MATERNITY BENEFITS

This section should clearly include coverage for family planning services including coverage for abortion. Both have made undeniable contributions to improved maternal and infant health and cannot be sacrificed on the altar of political expediency. In addition, all cases of elective induction of labor or Caesarian section which results in a preterm infant should be subject to peer review. A second opinion should be required prior to these procedures. Fees for uncomplicated, elective C-section should not exceed those for vaginal delivery.

TITLE II, PART D. SPECIAL POPULATION BENEFITS

This section attempts to address barriers other than money by providing for transportation, outreach or social and nutritional services. In my opinion these services are best provided under other locally controlled programs: Title XX, WIC, and Title V. They also can address other barriers not mentioned.

TITLE III, ADMINISTRATION AND METHODS OF PAYMENT OF BENEFITS

I would only make a few comments. I oppose the use of fiscal intermediaries as they have a built-in conflict of interest in increasing claims processing costs, no commitment to cost containment and add additional costs by way of profit or administrative expenses. They provide no services or and do not support such a data analysis unless it is included in their contracts which generally prove to be inflexible instruments of public programing.

I oppose co-payment as a utilization control device especially for cost effective elective prevention services and ambulatory care. There is little hard evidence to show that it is truly effective at reducing excessive utilization and contributes to inappropriate underutilization. Generally pregnancy related services are not subject to overutilization.

I understand a new Section 307 has been added, "consultation with State agencies." I would like to make a plea that, this be, written in such a way as to maximize the role of the State Title V agency in carrying out the necessary planning, standard setting, and innovative delivery system changes, that are needed if this program is not to degenerate into an expensive medicaid for children, with all the abuses and inadequacies, poor or absent providers, participant misuse and dissatisfactions, etc., that have plagued that program.

Finally, I understand that Section 333 provide for grants to provide special population benefits. This is, in my opinion, a totally impractical idea. Literally thousands of grants might be required with Health, Education and Welfare having little detailed knowledge of local applicants or needs. Again, I believe this should be handled through the Title V allocation to states, subject to federally approved plans.

TITLE IV. FINANCING THE MATERNAL AND CHILD HEALTH PROGRAM

This title has been amended but retains the concept of 0.1 percent of income will be used to establish a Trust Fund. I oppose the use of the fixed figure deducted from income and propose a graduated percentage so that the, higher income brackets pay more. I support the addition of Section 403 which includes unearned income over $400. The Congress should not be adverse however to using general tax revenues to keep the fund solvent, and should not rely on what has become a regressive social security tax system.

Lastly, I would like to make the single most important point of my testimony. Until this admittedly experimental system has been implemented and its strengths and weaknesses determined, the Congress should continue to support the existing programs for mothers and children, the most significant and effective of which is

the Title V MCH and CC program. Some have criticized this program as not having met the total needs of mothers and children, but I would like to remind you that the total appropriation for that program has never exceeded $350 million while the program under discussion today would cost an estimated $11.7 billion. Within the limitations of funds provided, Title V has had an overall excellent record of providing needed service to hard to reach high risk population. While it is true that effectiveness varies from state to state this is as much because of lack of support and technical assistance from Health, Education, and Welfare as it is from lack of state willingness or commitment.

It is a well established system—a base upon which a better program can be built. It contains hundreds of experienced, capable specialists in Maternal and Child Health services and has attracted state and local funds. Many of its detractors fault it for not doing what it was not designed to do namely be a fee paying medicaid for mothers and children. Rather, its mission is to determine the real status of maternal and infant health, identifying high risk groups demographically and geographically, organize services, provide seed money, training money and demonstration funds to get needed service started or coordinated. I could give numerous examples of how Maternal and Child Health has improved access and quality of care in ways impossible for Title XIX of this Act to do. Therefore I most strongly recommend Section 517, be amended to read:

CONFORMING AMENDMENTS

Section 503(a).—Title V of the Social Security Act is amended by adding at the end thereof the following new section.

PAYMENTS FOR SERVICES UNDER MATERNAL AND CHILD HEALTH CARE ACT

Section 517.—No payment may be made under this Title for the furnishing of services which would be eligible for payment as a covered service under the Maternal and Child Health Care Act unless specifically approved by the Secretary as a part of the state Title V plan. This does not preclude the state Title V agency from providing funds to encourage the establishment of new service facilities, training of needed personnel, development of standards of care, or collection of data needed to assess the status of Maternal and Child Health in the state.

Thank you for your attention. I would be most pleased to answer any questions

Mr. SCHEUER. Dr. Shinefield, you may proceed.

STATEMENT OF HENRY SHINEFIELD, M.D.

Dr. SHINEFIELD. Thank you, Mr. Chairman, for allowing me to appear. My name is Henry Shinefield. I am chairman of the California State Child Health Board. I am a pediatrician. I am chief of pediatrics at the Kaiser-Permanente health plan and I'm clinical professor of pediatrics at the University of California. The hat I wear in testimony today is as the chairman of the California Child State Health Board [see p. 247].

First, I would like to tell you that I, too, support your bill and I think it is an entirely reasonable approach to health insurance. A limited program from which we can learn would be more reasonable than a total commitment with all its problems.

Now about our health program for children in California. The chairman of the child State health board was created by legislation which also created a program which was called the child health and disability prevention program (CHDP).

The board, of which I am chairman, is comprised of nine individuals. Three are parents of children who are eligible for the program; one is a member of a child advocate organization; three are pediatricians;

one is a nurse child health specialist; and one is a county health officer. There are two ex-officio members of the board; one is a representative of the department of health and one is a representative of the department of education. It is a broad based board that represents above all else child advocates that are coming to a child health program with a variety of points of view.

One of the immediate goals of the CHDP was to be certain that all children who enter the first grade of school in the State of California has a health assessment examination. Moneys were appropriated to pay for the assessment of children with families with incomes up to the level of 200 percent of poverty. In this specific target population, in the fiscal year 1976–77, 74 percent have been assessed—a reasonably successful program, I think; however, I hasten to add that if we consider the entire target population of Medi-Cal eligibles between the ages of zero to 20, and public and private school enrollment, as estimated by the department of finance, we have something like 1.6 million children. Therefore overall—only 10.7 percent of the target population has had a health assessment. This, undoubtedly, is an underestimate, primarily because of the inaccuracies involved in the current methods of accumulating data; one of our main problems in the program, namely, accurate data accumulation.

In essence, Mr. Chairman, we have begun a program in the State of California for delivery of health care for children in California—both assessment and preventive health services—in an organized fashion. For aspects of the program which include outreach and health education, health assessment, referral and followup, integration and coordination of child health services—administration and management, evaluation and planning, I refer you to our recent elucidated 5-year plan for the CHDP program, a copy of which I have submitted. This document details the problems and needs that we've encountered, as well as our objectives and activities that we are pursuing and intend to pursue. In the few minutes allotted to me, I would like to emphasize two points which I consider essential ingredients to our current endeavor to make our program successful.

First, I am not sure that all individuals involved with this program and who expect this program to be successful realize the complexities of such an undertaking. Even in our legislation, the moneys that were appropriated for screening, there were no moneys appropriated for followup or for diagnosis of treatment.

Mr. SCHEUER. Are you talking about EPSDT or——

Dr. SHINEFIELD. But, let me make my two points.

Mr. SCHEUER. Please do.

Dr. SHINEFIELD. The first point I would like to make is, if the intent of the program is to be carried out in such a manner that all children of this State receive preventive health services and are indeed incorporated into a health care system, it is imperative that the cooperation of all individuals who are involved in such programs be protagonists of the program. In essence, it means we must develop a wide, enthusiastic endorsement of the program by all the providers, public, private, the consumers and a variety of intermediaries including schools. Incidentally, it's the same kind of task we'll face on a national level, if the same type of program—is to be administered to all children in the United States.

It is not sufficient to mandate a program and delegate the implementation of such a complex program narrowly and expect it to be successful. In this context, I would emphasize the second point that I would like to make. An essential ingredient of our program is the fact that the legislation mandated the creation of the State child health board which performs a very important function. It is the first time that such a board has been created in any legislative health program.

This body serves as a child's advocate. It is not an arm of the State health department, nor does it serve the interest of any group other than children. We are not interested in quick and easy solutions. We are interested in helping put together a health program for children.

For example, fees have to be appropriate for providers. The forms have to be simple so that individuals can cope with them. These are some of the problems that we, as a child State health board confront and help solve. We hold our meetings in a variety of locales throughout the State and get a first hand report on how things are going. Our meetings attract 50 to 75 people that are involved with the program and hear from them directly.

It's not a perfect program, yet, but it has the format for being a damn good program and for delivering preventive services and getting kids in a health care system and——

Mr. SCHEUER. And that's what it is all about!

Dr. SHINEFIELD. Let me give you an example. One of our best meetings was in Los Angeles. A group of pediatricians, who didn't understand the program, came to our board meeting. Dialog was established between county health people and the pediatricians. When it became apparent that funds were available for instruction to show the private sector how to fill in forms we gained advocates for the program who began to participate as they came to understand the program. We cannot exclude any provider if we are to have a successful program. At least, we must make the honest attempt to hear them out, to hear what their problems are, and attempt to solve them. We may not solve them all, but we must go out and do the best we can.

Mr. SCHEUER. At least, you've given them a forum.

Dr. SHINEFIELD. Absolutely. And, also, it is interesting enough, when they were exposed to that forum, we have an opportunity of incorporating many of those ideas because (1) they may not cost money, (2) or if they cost money, they seem reasonable. I want to say that, again, as you know, not enough money is given for preventive health for children or for children's health programs in general.

Mr. SCHEUER. That's the whole purpose of this bill.

Well, children are about one-third of our population and we spend less than 10 cents out of every health dollar on them.

Dr. SHINEFIELD. And a tragedy.

Mr. SCHEUER. It is a tragedy.

Dr. SHINEFIELD. Then, let me in summary say I would emphasize that the State child health board serves to explore the needs of all providers, and the needs and expectations of the children and their families, and what is feasible and reasonable.

Mr. SCHEUER. Wouldn't you say that, taking the state of the art as a given, there is a lot more unfulfilled potential for spending more

money and applying more resources in the preventive health education; nutrition education area, than there is in extending what is now known in the state of the art as curative sickness care.

Dr. SHINEFIELD. By addressing the needs and expectations of these groups in the early phases of formulation and implementation of all aspects of this program, we are attempting to make advocate and protagonists of the CHDP Program rather than creating antagonists.

Mr. SCHEUER. In this service of yours, are you treating the matter of nutrition care—are you providing nutrition education, nutrition counseling?

Dr. SHINEFIELD. As best you can.

Mr. SCHEUER. Yes.

Dr. CUNNINGHAM. And our job, at the local level, as bureaucrats, is to take these separate pots of money and try to integrate them into a total program. So we are trying to use the WIC program as the money to provide the nutrition education aspect of the program. We are trying to insist that all of the people in the WIC also participate as CHDP providers and by interlocking regulations, maximize the use of money.

Now, what he said in the beginning about the program being doomed to failure needs explanation. It was doomed to failure because of the mandate that was laid on us as an agency.

Mr. SCHEUER. He's talking about EPSDT?

Dr. CUNNINGHAM. Right. We were not given the right resources. That's like giving Michelangelo a toothbrush and a bucket of blue paint and saying, "Paint the Cistine Chapel." Now, it is a great idea and he has all kinds of imagination and you can't fault Michelangelo for his inspiration and his desires, but you can't also expect that he is going to produce, you know, what is expected. That is why he said the program was doomed to failure.

Mr. SCHEUER. You are pointing the finger right where it belongs—they didn't get the resources necessary to carry out the program.

Dr. SHINEFIELD. I would simply say that at the State child health board, we believe that we are having some success in this role as the independent child advocate.

I notice that in the proposed legislation the child health board was initially proposed and now such a board has been deleted from the program. Well, I strongly urge you to put such a board back into the program.

Mr. SCHEUER. Does your board actually run the program or do they simply have advisory input?

Dr. SHINEFIELD. Well, we are advisory but we have some policymaking powers regarding health standards of children. I would give them additional policymaking powers.

I hope that the intent of future legislation is to correct this and establish a concept that a health program should not be an appendage to a welfare program.

It is important to recognize health care needs, particularly, preventive health care needs, as appropriate primary considerations. The authority and responsibility for the delivery of such care should be made through primary health and medical agencies and sources.

Again, my two points are the fact that we are getting a lot of local input and using many resources available. We are not trying to build a new health resource. In coordinating such a program we have found that a child health board is an important advocacy body that mediates and sees to it that things get done. Thank you.

Mr. SCHEUER. Well, thank you very much. I'm very grateful for your testimony. I'm very intrigued by the story you gave us about your State child health board and I would be very much interested in getting your views on how we can integrate those kind of concepts in our bill. I hope you will give us detailed information on what this State child health board does. It mediates; it sets policy. Let us know the extent to which it gets into actual program direction and program control; give us as clear a delineation, as you can, of the actual functions that it has and the role that it plays. It is very intriguing.

Dr. CUNNINGHAM. Just one comment that Dr. Shinefield mentioned. There is also in the legislation, at each county, a county advisory board that works with the county program. They help the county in the same ways that the State board helps the State. They look at the county hospitals, the county providers, the county health departments and I think Dr. Bruyn may elaborate on that point.

Mr. SCHEUER. If it isn't already in your testimony, we would like an additional memo on exactly how the county boards work, too, including their policymaking role and their mediator role, in as much detail as you can give it to us.

Dr. SHINEFIELD. Yes; as a matter of fact, you have about 95 percent of that right now. The powers, duties, and responsibilities of the board, which I have also summarized, are a part of the paper which you have.

Mr. SCHEUER. Thank you very much.

[Testimony resumes on p. 296.]

[Dr. Shinefield's prepared statement and attachment follow:]

STATEMENT OF HENRY SHINEFIELD, M.D., CHAIRMAN, CALIFORNIA CHILD STATE HEALTH BOARD

My name is Henry Shinefield. I am Chairman of the State Child Health Board, I am a pediatrician. The State Child Health Board (SCHB) was created by legislation submitted by Assemblyman Willy Brown under assembly bill # 2068 which was signed by the Governor in 1973 and assembly bill 4284 signed by the Governor in 1976. The regulations regarding the Child Health and Disability Prevention Program (CHDP) and SCHB have been deliniated in the California Health and Safety Code 306.5 amended by chapter 1208 statutes of 1976. The intent of the legislative act is to establish a Child Health and Disability Prevention Program, which is financed and have standards established at the State level and which is operated at the local level for the purpose of providing early and periodic assessment of the health status of children. It is further intended that CHDP shall make maximum use of existing health care resources and shall utilize as the first source of screening the child's usual source of health care so that health screening programs are fully integrated with existing services, that health care professionals be appropriately represented and utilized in these programs, that outreach programs be developed to stimulate the use of preventive health care services, and that services offered pursuant to this part be efficiently provided and be of the highest quality.

The State Child Health Board is comprised of 9 individuals. Three are parents of children who are eligible for the program, one is a member of a child advocate organization, three are pediatricians, one is a nurse child health specialist, and one is a County health officer. There are also two ex-officio members of the board, one is a representative of the Department of Health and one is a representative of the Department of Education.

The powers, duties and responsibilities of the board are:

A. To review the standards of health screening, evaluation, and diagnostic procedures for Community CHDP Programs.

B. To review the standards for Directors of Community CHDP Programs.

C. To review standards of public and private health providers, facilities, and agencies which participates in community CHDP Programs.

D. To advise the Director on the development of a five year State Plan for CHDP Programs.

E. To periodically review all CHDP services within California and conduct independent investigations and studies as necessary.

One of the immediate goals of the CHDP Programs was to be certain that all children who entered the first grade of school in the State of California had a health assessment examination. Monies were appropriated to pay for the assessment of all California children with a families income up to the level of 200% of poverty. In this specific target population in the fiscal year 1976-1977 74.0% have been assessed. I hasten to add, however, that if one considers the entire estimated target population consisting of medi-cal eligibles between the ages of 0-20 and public and private school enrollment as estimated by the department of finance, only 10.7% of the target population has had a health assessment. This undoubtedly is an underestimate primarily because of the inaccuracies involved in the current methods of accumulating data. In any case, Mr. Chairman, we have begun a program in the State of California to assess the health of children in California and deliver preventive health services in an organized fashion. For a detailed outline of the program, our long term goals and action plans for various aspects of the program which include outreach and health education, health assessment, referral and follow-up, integration and coordination of child health services, administration and management and evaluation and planning, I refer you to our recently elucidated five year plan for the CHDP Program. This document details the problems and needs that we have encountered as well as our objectives and activities that we are pursuing and intend to pursue. In the few minutes allotted to me I would like to emphasize two points which I consider essential ingredients of our current endeavor to make the program successful.

First, I am not sure that all individuals involved with this program and who expect this program to be successful realize the complexities of such and undertaking. If the intent of this program is to be carried out in such a manner that all children of this State receive preventive health services and indeed are incorporated into a health care system, it is imperative that cooperation of all individuals who are involved in such a program become protagonists of the program. In essence it means that we must develop a wide enthusiastic endorsement of the program by all the providers, public and private, the consumers and a variety of intermediaries. Incidentally, this will be the same task that we will face on a National level if the same type of program is to be administered to all children in the United States. It is not sufficient to mandate a program and delegate the implementation of such a complex program narrowly and expect it to be successful.

It is in this context that I would emphasize the second point I would like to make. An essential ingredient in the California program is the fact that the legislation mandated the creation of a State Child Health Board. It is this body that serves as the child's advocate. It is not an arm of the State Health Department nor does ot serve the interest of any group other than children. Unfortunately, the quick and easy solutions to problems that have frequently surfaced may not be the best solution to that specific problem. It is the function of this board to be certain that in approaching these problems none of the health needs of the child are compromised. The SCHB serves to explore the needs of all providers, the needs and expectations of the children and their family as well as others who are involved in the program, such as those individuals involved in the educational system. By addressing the needs and expectations of all these groups in the early phases of formulation and implementation of all aspects of this program we are attempting to make advocates and protagonists for CHDP rather than creating antagonists.

We believe we are having success in this role of the independent child advocate. I noticed in the proposed legislation that the Child Health Board was initially proposed and now such a board has been deleted from the program. I strongly urge you to put such a board back into the program and give the board not advisory powers but policy making prerogatives.

One general word about the CHDP Program, or as a matter of fact any health program. I am sure others will address this as others have throughout the past years. The current Medicaid program we have is in essence a bill paying program. I hope the intent of the future legislation is to correct this and establish the concept that a health program should not be an appendage to a social security program. It is important to recognize health care needs (particularly preventive health care needs) as appropriate primary considerations. The authority and responsibility for the delivery of such care should be made through primary health and medical agencies and sources.

Child Health & Disability Prevention Program Five-Year Plan: FY 1978-82

State of California :: Department of Health
Child Health & Disability Prevention Branch

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY
EDMUND G. BROWN JR., Governor

DEPARTMENT OF HEALTH
714-744 P STREET
SACRAMENTO, CALIFORNIA 95814
(916) 322-4780

December 12, 1977

TO: Those Interested in the Child Health and Disability Prevention Program (list of addressees attached)

SUBJECT: Child Health and Disability Prevention Program's Five Year Plan

Enclosed for your information is a copy of the Child Health and Disability Prevention Program's Five Year Plan, as adopted by Dr. Jerome A. Lackner, Director, California State Department of Health.

CHDP extends its sincere thanks to the many people who provided ideas and suggestions for this plan. We regard it as a flexible management tool and part of an on-going process of program development. We will continue to welcome comments directed to improvement in the Child Health and Disability Prevention Program.

Frederick B. Hodges M.D.

Frederick B. Hodges, M.D., Chief
Child Health and Disability
Prevention Branch

Enclosure

Addressees:

State Child Health Board

CHDP Directors and Deputy Directors

CHDP Advisory Board Chairpersons

California Conference of Local Health Officers

Local Health Department Maternal and Child Health Directors

California Conference of Local Directors of Health Education

California Conference of Local Health Department Nursing Directors

Senate Committee on Health and Welfare
Task Force on the Child Health and Disability Prevention Program

School Health Alliance

Department of Health, Education, and Welfare

CHDP Coordinating Committee

State Department of Health, Public Health Division
Faustina Solis, Deputy Director, Public Health Division
Public Health Division Branch Chiefs
Esmond Smith, M.D., Chief, Crippled Children Services Section
Edward Kolia, M.D., Chief, Maternal and Child Health Services Section
Jack Julien, D.D.S., Chief, Dental Health Section
James Chin, M.D., Chief, Infectious Disease Section
Loyd Bond, M.D., Chief, Contract Counties Health Services Section
Ismael Zarate, Chief, Rural Health Section
Winona Semple, Chief, Indian Health Section
Thelma Fraziear, Chief, Office of Family Planning

State Department of Health Budget Office

Office of Health Planning

Legislative Analysts Office

Department of Finance

CHDP Branch Staff

Interested Members of the Public and Department of Health
(State Child Health Board Mailing List)

CHILD HEALTH AND DISABILITY PREVENTION PROGRAM

FIVE-YEAR PLAN

FISCAL YEAR 1978 - FISCAL YEAR 1982

Adopted by the California State Department of Health
As Required by Section 306.7 of the Health and Safety Code
Jerome A. Lackner, M.D., Director
October 1, 1977

Prepared by:

Child Health and Disability
Prevention Branch
Public Health Division

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY
EDMUND G. BROWN JR., Governor

DEPARTMENT OF HEALTH
714-744 P STREET
SACRAMENTO, CALIFORNIA 95814
(916) 322-4780

September 20, 1977

Jerome A. Lackner, M.D., Director
Department of Health
714 P Street
Sacramento, CA 95814

Dear Doctor Lackner:

ENDORSEMENT CHDP FIVE YEAR PLAN

At its meeting of August 25, 1977, the State Child Health Board reviewed the draft of the Child Health and Disability Prevention Program's Five Year Plan and voted unanimously to approve the draft, as a working document for CHDP program development. The Board is satisfied that the Plan being submitted to you has been developed with the participation of a wide range of individuals and organizations and that it represents the comments and concerns of this body and those who have presented their concerns to us.

As reflected in the introductory statement of the Plan, the Board determines the purpose of this document to be dynamic not static, more flexible than rigid, and oriented towards an evolutionary and on-going planning process. The Board is convinced that this approach is appropriate and sensible in light of the anticipated further development of CHDP's data and evaluation capacities.

Therefore the State Child Health Board; having carefully reviewed the CHDP Five Year Plan, hereby submits it to you Dr. Lackner and the Department of Health with our favorable endorsement and recommendation in keeping with the provisions of Assembly Bill 4284.

Sincerely,

Henry R Shinefield

Henry Shinefield, M.D., Chairman
State Child Health Board

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CHILD HEALTH AND DISABILITY PREVENTION PROGRAM

FIVE-YEAR PLAN

I. Statement of Purpose of the Plan

In 1976, AB 4284 amended California's Child Health and Disability Prevention (CHDP) Program and required that the State Department of Health "... adopt a five-year state plan for child health and disability prevention services by October 1, 1977". This plan has been developed as a basic tool for management of the CHDP Program. It is viewed as a working document for an ongoing process of program planning and development. The plan identifies problems, describes underlying values and an ideal system of child health care, and proposes CHDP goals, objectives, and priorities.

In developing the plan, CHDP has been guided by the legislative mandate that CHDP be "...a community-based program, operating within a framework provided by state legislation, financing, and standards". The plan is intended to be a five-year projection of the state framework of the CHDP Program, based on the premise that this framework should provide both the support and flexibility which will allow local CHDP programs to meet the health needs of children in widely varying California communities. In addition to the statewide program development activities outlined in the plan, state CHDP staff will continue to respond to the specific needs of individual counties through consultation and technical assistance.

In the plan, reference is made to the various years as "Year 1", etc., which refers to fiscal years as follows:

Year 1	Fiscal Year 1977-78
Year 2	Fiscal Year 1978-79
Year 3	Fiscal Year 1979-80
Year 4	Fiscal Year 1980-81
Year 5	Fiscal Year 1981-82

The State Child Health Board is established by CHDP legislation to play a major consultative role in the CHDP Program. To highlight their role with regard to this plan and overall program development, the State Child Health Board has adopted this statement:

> By virtue of legislative intent contained within Assembly Bill 4284, the State Child Health Board shall play an active role in the formation, planning, and ongoing implementation of the five-year plan.
>
> By the end of Year 1, the State Child Health Board shall have specified and initiated its precise role in the development of the CHDP Program.

When needed, the Board may utilize available department staff to assist its periodic review and evaluation of the plan. The Board shall also advise the Director of the plan's progress as it deems necessary.

II. Description of the Planning Process

The CHDP Program is a complex program which requires the cooperation and coordination of many people and agencies. The process used to develop this plan included participation by all the various groups which are involved in CHDP:

CHDP Branch Staff

State Child Health Board

Local CHDP Programs

- Directors/Deputy Directors
- Health Educators
- Nursing Directors
- Other Staff
- Welfare Departments
- Advisory Boards
- Schools
- Providers and Other Health Professionals (Physicians, Public Health Nurses, School Nurses, Dentists, etc.)
- Parent Groups

Professional Groups

- Executive Committee of Local CHDP Directors/Deputy Directors
- California Conference of Local Health Officers
- California Conference of Local Directors of Health Education
- California Conference of Local Health Department Nursing Directors
- American Academy of Pediatrics, California Chapter
- California Medical Association
- California Welfare Directors Association

State Agencies

- Department of Education
- Department of Consumer Affairs

Division of Medical Assistance

Social Services Division

Department of Benefit Payments

Maternal and Child Health Branch

Infectious Disease Section

Rural Health Section

Dental Health Section

Indian Health Section

Crippled Children Services Section

Treatment Services Division

Developmental Services Program

Office of Statewide Health Planning and Resource Development

Contract Counties Health Services Section

Consumer Groups and Child Health Advocates

Children's Lobby	Western Center on Law and Poverty
Steve Thompson	School Health Alliance (Including California School Nurses Organization, California PTA, California School Health Association, California School Boards Association, California Nurses Association)
National Health Law Program	Children's Rights Group
Los Angeles Legal Aid	County Supervisors Association

CHDP requested suggestions for the five-year plan from each of these groups, and these suggestions were used to develop the first draft of the plan. Subsequently, all participants were given an opportunity to review the draft and submit comments to CHDP. Feedback from participants was used to revise the draft and develop this document.

II. Child Health Needs/Problems in California

This plan addresses the need for preventive health care for California children and young adults. For the purposes of the plan, preventive

health care includes: (a) measures designed to prevent the emergence of health problems and (b) early identification and treatment of health problems in order to prevent or minimize disability. The health care system in California currently has preventive tools of both types, but they are frequently underutilized and/or unavailable. Many children continue to suffer from preventable disease and disability.

Very limited data are available to define the adequacy of preventive health care available to California's children. Immunization levels have some validity as an indicator of adequacy of preventive care since immunization is one of the most basic components of any preventive care regime. A 1976 statewide survey of California kindergarten students indicated the following percentages of inadequately immunized children: polio, 14 percent; DPT, 10 percent; measles, 11 percent; rubella, 33 percent; mumps, 47 percent. 1/

The most detailed information available on the unmet need for preventive care comes from national sources. Federal studies have shown that:

A. Between 20 percent and 40 percent of children in low-income families suffer from 1 or more chronic illnesses. Only 40 percent of these children are under treatment.

B. Three to six percent of all children given hearing tests in the schools have significant hearing impairment. Of these children with hearing impairments, three-fourths will respond to proper medical treatment.

C. Ten percent of all children between the ages of 6 and 11 have vision problems. Only 40 percent of children in low-income families between the ages of 6 and 11 have these known vision handicaps corrected.

D. Ninty-six percent of all children require some dental care before age six. Only 40 percent of children in low-income families have ever seen a dentist before age 17.

E. Of the 15.2 percent of one group of 18-year-old males who had disabilities, it was determined that 62 percent of these conditions could have been prevented or corrected before the individual reached age 15. 2/

The 1973 Health Interview Survey, conducted by the National Center for Health Statistics, found that almost 11 percent of persons in the

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1/State of California, Department of Health, unpublished data.

2/Fact Sheet: "Medicaid's Early and Periodic Screening, Diagnosis, and Treatment Program", HEW, August 1974.

western United States under age 17 had never had a routine physical examination. Nationally, this figure rose to 20 percent for those from low-income families, and to 16 percent for all those from farm areas. 3/

In addition to care aimed at reducing the incidence of preventable disease and disability, there is a need for preventive care which seeks to promote positive health, i.e., an increased state of well-being. While this is a difficult concept to measure, its promotion is linked to such things as health education, nutritional counseling, developmental counseling, and the use of health assessment data to establish a baseline health profile.

Further accessibility to preventive care, as well as all care, is especially limited for certain minority groups and disabled groups.

It is important to recognize that some specific health care needs vary from infancy to adolescence. While the infant and young child are targets for immunization, developmental assessment, and parent counseling, adolescents require counseling and services related to their unique period of development and education to support positive personal health action.

The major barriers to receipt of preventive care are:

A. Lack of financial resources to pay for such care.

B. Lack of understanding regarding the benefit of preventive care.

C. Lack of information regarding the availability of preventive care.

D. Competing priorities for low-income families.

E. Lack of health care resources.

F. Lack of transportation.

G. Language and cultural barriers.

H. Insufficient integration of preventive and promotional methods into existing health care practice.

I. Fragmentation of existing preventive, diagnostic, and treatment services.

IV. Values Underlying the Program

In trying to meet the broad health needs outlined above, the CHDP Program has been guided and will continue to be guided by the following values:

3/USDHEW. Use of Selected Medical Procedures Associated with Preventive Care, United States — 1973.

A. Prevention is better than cure, and early detection can prevent disabling effects.

B. All individuals have a right to a state of health that is constrained only by their inherent individual limitations and to a level of health care that makes full use of existing knowledge related to achieving a state of positive well-being.

C. Achieving full health potential of individuals requires action by government, by the individuals themselves, and by health professionals who serve children.

D. California communities vary widely in size, population density, socioeconomic characteristics, geographic characteristics, and health resources. This variation mandates that any successful attempt to meet the health needs of children must be based on locally determined and operated programs which have the flexibility to create local solutions.

E. Individuals have the right to choose whether or not to accept the health care to which they are entitled, as well as the right to choose or refuse any action of their own which may benefit their health.*

F. Health care can make its greatest contribution to increasing health status when:

1. There are no separate systems of care for the poor.

2. All patients are treated with dignity and as responsible partners in achieving health.

3. Preventive and promotional measures are maximized rather than relying on treatment after the fact.

4. Health education is integrated into the health setting.

G. Health personnel should be used in appropriate roles so that health resources function as efficiently and effectively as possible. Much of prevention and early detection can be performed by personnel other than physicians (e.g., nurses, nurse practitioners, dental hygienists, health aides, health educators, nutritionists, physician assistants, etc.) and use of such personnel in appropriate roles should be encouraged.

H. All public programs must be accountable through ongoing evaluation.

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* The law recognizes that in extreme cases, a parent's inattention to a child's health problems may constitute neglect.

I. It is preferable to receive the spectrum of primary medical services (preventive care, primary diagnosis and treatment) from a single source of care which coordinates with dental services and specialized medical services. Such a source might be a private physician or medical group, a local health department, a prepaid health plan, etc. In the absence of integrated primary care, the spectrum of primary resources should be coordinated by other mechanisms and responsiblity for coordination clearly placed.

J. The patient should have full and informed control over the use and distribution of information relating to his/her health and health care.

K. Ensuring accessibility of all services to all residents without discrimination as to race, national origin, sex or physical or mental disability is essential to the successful operation of health programs.

V. CHDP Long-Term Goals

The long-term goals of the Program are as follows:

A. To reduce the incidence of preventable disease and disability in California. 4/

B. To increase the positive health status of California children.

C. To increase the preventive and "wellness" orientation of health care available to California children and make such care available in a coordinated, accessible way.

D. To increase health knowledge and positive health behavior of parents and children in California.

VI. Description of Current Program

A. Legislative Base.

The CHDP Program was established by the State Legislature in 1973 by AB 2068. This law was intended:

1. To provide a base for implementation in California of the federally mandated Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program for Medi-Cal eligible children; 5/ and

4/It should be recognized that early detection and treatment, while preventing disability, may increase the recognized incidence of certain health problems.

5/EPSDT Program: Federal program which requires states to make periodic health assessments available to Medicaid-eligible children ages 0-20; all states are required by federal law and regulations: a) to inform the parents of such children about the services; b) assist parents in receiving service; c) assure that services are received; d) assure that children receive any needed follow-up diagnosis and treatment.

2. To extend the preventive benefits of EPSDT to all California children ages zero - six.

The original legislation has been amended several times.

The law requires establishment of locally operated child health assessment programs in all California counties, with program standards and financing provided at the state level. It also requires that children entering first grade present proof to the school that a health assessment was received within the previous 18 months, unless the parent waives the examination.

B. Eligibility.

CHDP's enabling legislation states that the following groups are eligible for CHDP services:

1. Any child between birth and 90 days after entrance into the first grade.

2. All persons under 21 years of age who are eligible for the California Medical Assistance Program (Medi-Cal).

However, funds appropriated to the CHDP Program have never been sufficient to cover the cost of health assessments for all of these children. Therefore, CHDP has defined its target groups (i.e., those eligible for state-reimbursed services) as follows:

3. All Medi-Cal eligibles, ages 0-20.

4. All children 18 months prior to entry into first grade or 90 days after entry into first grade and who are within 200 percent of the Aid to Families with Dependent Children (AFDC) basic standard of need. 6/

Estimates of the size of the total target population are presented in Table A.

C. Services provided.

The three basic services provided under the CHDP Program are:

1. Outreach and education, to inform consumers and providers about the Program and motivate them to participate.

2. Health assessment (screening), to detect potential health problems and encourage health maintenance through health education and counseling.

6/AFDC basic standard of need: income standard based on family size and gross income; used by the AFDC program to assess eligibility for cash grants.

State of California
Department of Health

Center for Health Statistics
October 3, 1977

TABLE A

ESTIMATED STATEWIDE CHDP TARGET POPULATION
FY 1977-78 Through FY 1981-82

FISCAL YEAR	ESTIMATED TARGET POPULATION
1977-78	1,601,653
1978-79	1,674,800
1979-80	1,724,000
1980-81	1,794,700
1981-82	1,857,700

The target population estimates are based on:
1. Projected Medi-Cal Eligibles between the ages of 0-20.
2. Projected Public and Private School enrollment as estimated by the Department of Finance.

Note: The Medi-Cal population was estimated using a time series based on the count of Medi-Cal eligibles from 1974 through 1977. This method assumes that there will be no change in Medi-Cal eligibility requirements.

3. Referral to diagnosis and treatment, if needed, and follow-up to assure referrals are completed, through parent education and assistance.

Local CHDP programs and county welfare departments share responsibility for the outreach and follow-up for children eligible for Medi-Cal.

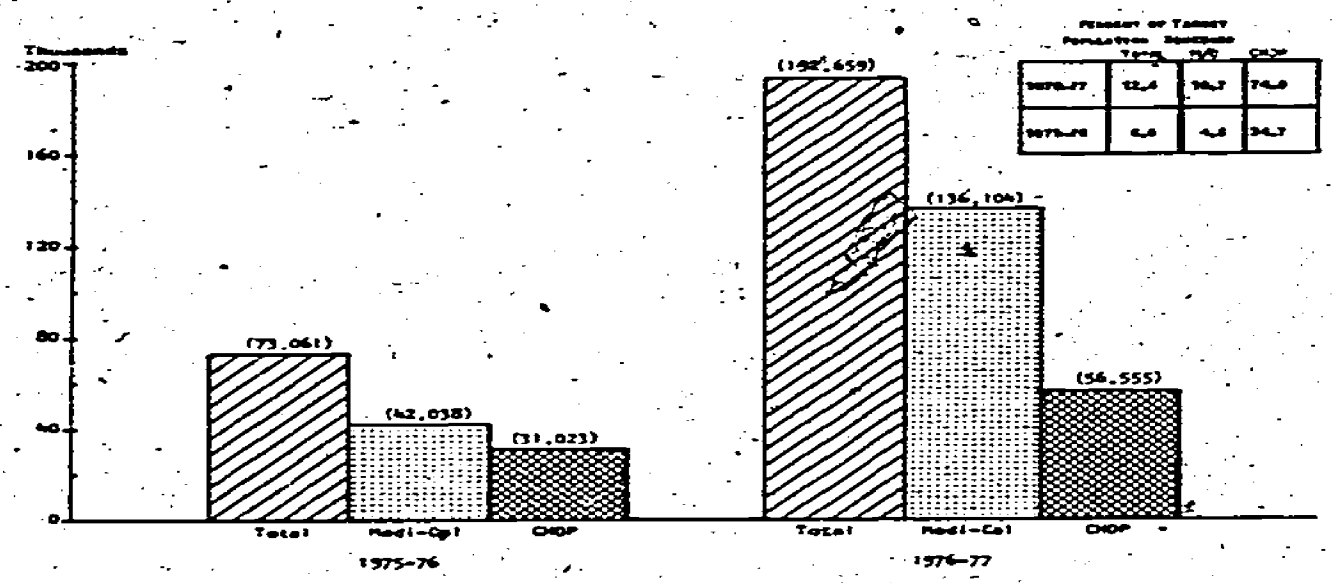
For Medi-Cal children, diagnosis and treatment are provided as part of the Medi-Cal program. While CHDP does not currently cover the cost of diagnosis and treatment for other children, CHDP referral and follow-up includes identification of other financial resources to pay for diagnosis and treatment.

D. Trends.

Trends in CHDP-reimbursed health assessment services are presented in Figure 1. Trends in CHDP health assessment expenditures are presented in Figure 2. Compliance with the CHDP health assessment requirement by children entering first grade in September 1976 is presented in Table B. (This is the first year for which data is available.) Figure 3 shows rates of referral for various assessment procedures.

FIGURE 1

CHILD HEALTH AND DISABILITY PREVENTION PROGRAM
SCREENING ACTIVITY FY 1975-76 vs. FY 1976-77

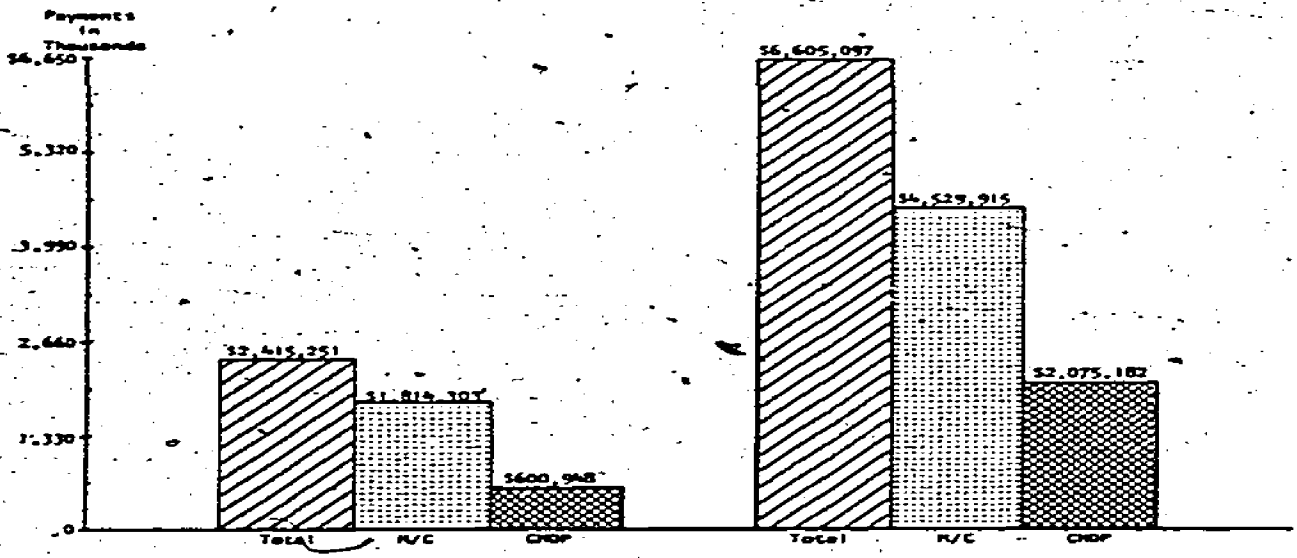


Note: The Medi-Cal Eligibles who were screened in FY 1976-77 includes 2912 Medi-Cal PHP Screens. Data on Medi-Cal PHP Screens for FY 1975-76 is not available.

Source: Automated Information System.

FIGURE 2

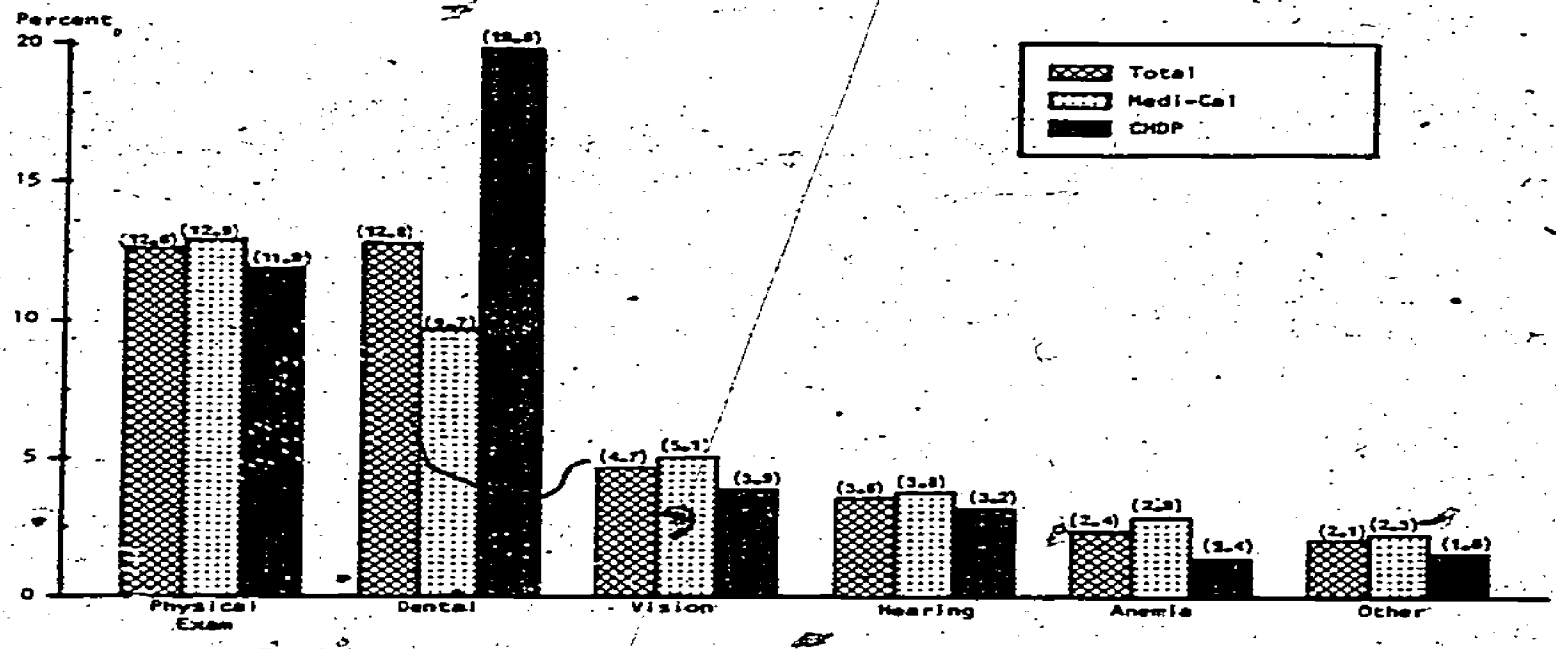
CHILD HEALTH AND DISABILITY PREVENTION PROGRAM
PAYMENTS FOR SCREENING SERVICES
FY 1975-76 vs. FY 1976-77



Note: The dollars released for payment may differ slightly from the Accounting Unit Reports due to the time lag between CHIC Unit release and actual payment by the State Controller.

Source: CHIC Unit Weekly Status Reports.

FIGURE 3
CHILD HEALTH AND DISABILITY PREVENTION PROGRAM
REFERRALS BY PROCEDURE CATEGORY
FY 1976-77



Note: The Other category includes: MED History, Nutrition, Measurement, Tuberculin, Urine Dipstick, Sickle Cell, Blood Lead, VD, Denver Development.

Source: Automated Information System.

Table B.

Compliance With Legal Requirement To Present Proof of Health Assessment Or Waiver When Child Enters First Grade FY 1976 - 1977

	Children Enrolled in First Grade as of Oct. 1		First Grade Children with Written Documentation of Health Assessment		First Grade Children with Waiver of Health Assessment		First Grade Children with neither Certification nor Waiver	
	#	%	#	%	#	%	#	%
Public School Districts	329,306	100%	195,963	60%	30,193	9%	103,150	31%
Private Schools	22,901	100%	16,356	72%	1,900	8%	4,645	20%
All Schools	352,207	100%	212,319	60%	32,093	9%	107,795	31%

Source: Annual School District and Private School Report of Screening Examinations and Waivers (PM 272)

Does not reflect data on school districts/schools which did not submit a report.

VII. Criteria for an Ideal System of Child Health Care

In developing objectives and activities for this plan, CHDP has defined criteria for a system of child health care which would be most ideal for pursuing the purposes of the Program, that is, a system which would allow the most effective achievement of CHDP's goals. We will not be able to build a system which meets all of these criteria in the next five years. Indeed, CHDP alone could not build such a system nor carry on all the activities involved. Nevertheless, defining such an ideal system of care gives important guidance and direction to the Program and provides a base for planning.

Criteria for an ideal system of child health care are outlined below. CHDP can be expected to support the development of such a system both directly and indirectly, with the expectation that responsibility for developing and managing any element of such a system might vary from community to community. Criteria for this system are as follows:

A. Easily accessible education in parenting and parent effectiveness.

B. Initiation of health care and entry into a system of care after birth in the hospital or within 48 hours of home birth.

   1. Education about well-child care, immunizations, and safety.

   2. Identification of a preferred source of well-child care and source of payment.

   3. Start a record which, with parental permission, is shared with the chosen source of well-child care, if a relationship with ongoing health care source is not already established.

   4. Appropriate discharge planning, to include finding out if the mother needs and wishes a public health nurse or any other allied health professional to visit her at home.

C. Contact with parents and newborn at home.

   1. Phone or visit within 48 hours of discharge.

   2. Home visit within 72 hours for first or high-risk baby or within two weeks for other babies: complete health evaluation of baby; evaluation of parent-baby relationship.

D. Adequate, accessible, coordinated system of health care providing well-child care, diagnosis, and treatment.

   1. Adequate financial access for all.

   2. Choice of available sources of care.

3. Quality of care is equal for all.

4. Active promotion of prevention.

5. Sensitive to special parent needs: working parents, single parents, non-English-speaking parents, changing role of women, and cultural and ethnic perspectives.

6. Responsibility for continuity clearly placed.

7. Integration of health education and family counseling into the health care setting.

8. Coordinated with full spectrum of dental care.

E. Coordination/integration of services to meet special needs.

1. Early diagnosis and treatment of developmental problems.

   a. Coordination of regional center, Crippled Children's Services, Mental Health Services, special education, etc.

   b. Accessible developmental centers with team approach to diagnosis and treatment (social worker, psychologist, public health nurse, school nurse, pediatrician, speech therapist, etc.)

2. Care for teenagers: annual checkup; VD services; contraceptive services; pregnancy testing and counseling; sexuality education; primary care.

F. School health education and health services.

1. Health examination for school entrance.

2. School follow-up of immunization requirements.

3. Implementation of K-12 comprehensive health education curriculum covering physical, mental, and social health, including values clarification and person effectiveness.

4. Education in parenting for parents enrolled in school.

5. On-site school nursing services which allow knowledge and evaluation of individual children.

6. With parental consent, communication between school nurse, the parent, and child's regular source of health care regarding the child's health, i.e., school nurse as extension of the health care system.

7. Parent education and assistance in use of local health care services.

G. System to coordinate care for mobile populations.

1. With parental permission, Health Department to start well-child record at birth and update through CHDP provider billings.

2. With parental permission, central state data system to record all immunizations required for school entry by date and source. Data to be accessed, with parental permission, through the local health department by any licensed physician, public health official, school nurse, or parent. Data entry to be required of all immunization providers.

H. Coordinated Child Health Services Planning.

1. Represents consumers and all agencies.

2. Evaluates local needs and resources.

3. Advises in development of child health services.

I. Confidentiality of child health records.

1. Requires informed parental consent to gather data and release data to others.

2. Insures parent's/person's access to file to inspect and correct.

Note: For the purposes of this plan, prenatal, perinatal, and neonatal care, and prenatal and newborn genetic screening are considered to be another system generally centered on specialized hospital services. We recognize that all these services also play an essential role in assuring the healthiest babies.

VIII. Planning Assumptions About Future Program Constraints

Several factors beyond the direct control of CHDP act as constraints upon the Program. The most important of these constraints are:

Reorganization of the Department of Health;

Changes in the EPSDT Program at the federal level;

State enabling legislation and appropriations.

A. Reorganization of the Department of Health

CHDP is an extremely complex program which relies for success on cooperation by many other organizational units. During the

past year, CHDP became a separate branch of the Public Health Division in the State Department of Health. This step, along with increased support from the Administration, was primarily responsible for great improvement in CHDP's ability to achieve the required coordination of activities.

While this plan is being written, proposed legislation would break up the Department of Health and establish a number of individual departments. The ability to effectively coordinate the CHDP Program would be impacted by any of the current reorganization plans which have been considered.

For the purposes of this plan, CHDP will assume that whether or not the reorganization takes place, CHDP will be able to maintain the necessary coordination through whatever increased efforts are required. However, if coordination requires increased resources, this will impact CHDP's ability to accomplish all objectives outline in the plan. The plan also assumes that CHDP should attempt to assure that its organizational fate is as compatible as possible with its need to assure coordination with others.

B. Federal changes in the EDSPT Program.

Two possible major changes in the EPSDT Program can be foreseen within the next five years — implementation of the Child Health Assessment Program (CHAP) legislation and implementation of national health insurance.

This plan makes two primary assumptions about these potential changes:

1. The major impact will be to increase financial resources for provision of CHDP services.

2. Time, energy, and resources will need to be diverted to cope with required changes in provision of service. This will be especially true if CHAP requires the phase-out of "screening only" providers. 7/ To the extent possible CHDP will attempt to assure that CHAP will allow "screening only" providers to continue to operate where comprehensive continuing care providers 8/ are not available. Diversion of resources to CHAP implementation may impact CHDP's ability to accomplish all objectives proposed in the plan.

7/Screening only providers: CHDP health assessment providers who do not provide follow-up diagnosis and treatment.

8/Comprehensive continuing care providers: CHDP health assessment providers who take responsibility for providing basic follow-up treatment and diagnosis and who agree to act as the child's basic source of care on an ongoing basis.

C. State enabling legislation and appropriations.

CHDP legislation has been amended several times in the past few years. While it is difficult to define the "reasonable" limits for further legislative changes, this plan assumes that seeking needed legislative change is a reasonable alternative for achieving CHDP goals.

Appropriations for CHDP services have never been sufficient to allow CHDP to pay for service for all children who are legislatively eligible for service. While acknowledging fiscal realities, this plan assumes that if the original intent of the Legislature was to serve a wider group of children than are currently being served, it is reasonable to seek additional appropriations for expansion of service when needed for achieving CHDP goals.

IX. Expansion of the CHDP Target Group

As stated above, CHDP's target population (i.e., those eligible for state-paid health assessment services) has comprised the following groups:

A. All Medi-Cal eligibles, ages 0-20.

B. All children 18 months prior to entry into first grade or 90 days after entry into first grade and who are within 200 percent of the AFDC basic standard of need.

Legislation makes all California children from birth to 90 days after first-grade entry eligible for CHDP services, and state-reimbursed health assessment could be extended to all or any part of this group, should money be available.

In 1977-78, state-reimbursed health assessment is being extended to all children enrolled in Head Start and the State Preschool Program. This group consists of approximately 34,000 children, over half of whom are already eligible for state-reimbursed CHDP services through Medi-Cal.

During the next five years, CHDP plans to address the question of further expansion of services through the following priorities.

First Priority: To define more concretely the impact of CHDP services on its current target group and the need for CHDP services.

Rationale: Continued legislative support for the existing program will require better data on program need and impact. Program planning also requires better data.

Second Priority: To promote more complete financial resources for diagnosis and treatment for those who are currently receiving health assessment and who require follow-up.

Rationale: Low-income families who are not Medi-Cal eligible find it difficult and sometimes impossible to pay for indicated diagnosis and treatment. Identification of potential problems where financial resources for diagnosis and treatment are not available is a disservice to the child. Before new groups are added to our target population, gaps in follow-up must be identified and filled. Resources need not be provided by CHDP, but CHDP must work to assure that resources are available.

Third Priority: Where feasible, to extend state-paid services to children who are already enrolled in other public health programs (WIC, Children and Youth Projects, etc.) and who are not Medi-Cal eligible.

Rationale: Varying eligibility in public health programs creates fragmentation. Virtually all children in public health programs are high-risk children and should receive a full spectrum of care.

Fourth Priority: To make a wider range of low- and moderate-income children in the school entry group eligible for state-paid services and to extend state-paid services to infants (birth - 12 months) on an income eligible basis.

Rationale: When CHDP can demonstrate its impact on current target groups and assure availability of diagnosis and treatment, support for expanded services should be sought:

1. To assure financial access to health assessment for all children who are required by law to receive an assessment for school entry.

2. To decrease financial barriers to preventive health care in infancy, when potential problems can be detected as early as possible and preventive health maintenance counseling can have its greatest impact.

Impact of health assessment of infants will be explored through pilot projects in Contra Costa and Sonoma Counties beginning in 1977-78.

Fifth Priority: To gradually expand state-paid services from the infant group to age four-and-a-half, on an income-eligible basis, to close the gaps in the legislatively mandated target group.

Rationale: If there is demonstrated need and success, the entire legislative mandate to serve children from birth to 90 days after first-grade entry should be accomplished, at least for children with the greatest financial barriers to care.

Sixth Priority: To make state-paid periodic health assessment services available to all California children from birth to 90 days after first-grade entry.

Rationale: Identification of low-income children in the health care system is undesirable. Although this priority represents the most preferable system, it would be difficult to attain through state action alone.

X. Action Plan for Outreach and Health Education

A. Problems and needs.

The following problems and needs have been identified with regard to outreach and health education.

1. Outreach to Medi-Cal families needs to be expanded and improved so that more children receive preventive services and begin receiving them as early as possible in life.
2. The State should provide more leadership and coordination in the development of a public information program, 9/ including expanded use of the public media.
3. The State should provide support to improving the health education component of the CHDP health assessment.
4. Medi-Cal teenagers need to be motivated to use CHDP services.
5. Community groups are inadequately used to build support for use of CHDP services and other preventive health behavior. CHDP should outreach to the community for greater support and provide measures to involve the community in the CHDP evaluation process.
6. If schools were to stress health assessment before kindergarten entrance, outreach opportunities would be increased through personal contact at kindergarten preregistration and use of the kindergarten year to follow up with those children not yet assessed.
7. Schools need more support in providing outreach to parents.
8. Outreach and education of private providers is needed to expand the CHDP service network.

9/Public information program: as part of a health education program, use of any appropriate media (whether written or audio-visual) to effectively reach the target populations.

9. CHDP should support increased health education in schools.

10. Assessment results show that dental problems are very common and the need for preventive dental education is great.

B. Objectives and activities.

1. Objective: By Year 5, to have the following percentages of the Medi-Cal population with an up-to-date medical record 10/ and receiving screens each year.

	Total Medi-Cal Population 0-21	Medi-Cal 0-6	Medi-Cal 7-21
Up-to-Date Medical Record	70%	80%	60%
Screened Annually	35%	50%	25%

a. Subobjective: By Year 2, for all counties to have increased the use of intensive outreach, with the purpose of increasing the number of parents who are interested in obtaining health assessment for their children.

(1) In cooperation with the Social Services Division, assist in developing the outreach activities of the newly funded EPSDT units. 11/ — Year 1

(2) Hold jointly sponsored workshops to provide training skills, materials, and models to local health and welfare departments. — Year 1 and continuing

(3) Cooperatively identify successful local outreach programs and make materials and consultation on successful programs available to counties. — Year 1 and continuing

b. Subobjective: By Year 2, to establish a statewide public information program to assist in increasing the number of Medi-Cal eligibles who receive health assessment.

10/Up-to-date medical record: CHDP medical record indicates that screening or preventive health care is current (some children will not need screening during the year; others will receive care from non-CHDP providers).

11/EPSDT Unit: Activities within local CHDP programs and county welfare departments which receive special federal and state funding for the purpose of improving the EPSDT component of the Program (i.e., outreach, assessment, and follow-up of children eligible for Medi-Cal).

(1) With assistance of the Public Information Committee, to develop and monitor a contract for a statewide public information program. — Year 1

(2) Sample surveys to determine information program impact. — Year 2

c. Subobjective: By Year 3, to increase the incorporation of existing community organizations (e.g., parent groups, PTAs, neighborhood organizations, community centers, teen groups, professional organizations, etc.) into the CHDP outreach network in six local CHDP programs.

With interested local CHDP programs, identify and meet local needs for assistance in community organization skills and methods. — Year 2

d. Subobjective: By Year 3, to increase the percentage of Medi-Cal and other families who receive information during their child's early infancy about the importance of early and periodic preventive health assessment.

(1) Provide materials and training to local health and welfare departments that would enable them to train EPSDT workers, eligibility workers, and social workers to educate pregnant women about the importance of early and periodic preventive health assessment for children. — Year 2

(2) Outreach to others having contact with low-income pregnant women (e.g., physicians, prenatal programs, school programs for pregnant women, school nurses) to encourage the integration of information about CHDP and periodic preventive care into prenatal care/education. — Year 3

(3) In cooperation with interested local CHDP programs, develop and hold workshops in development of hospital-based outreach programs. — Year 4

e. Subobjective: By Year 4, to increase referral of Medi-Cal school children, other than first-grade enterers, to CHDP services by schools.

(1) Pilot research project to fund schools in low-income areas to perform CHDP outreach and preventive health care education, using school nurses or other school personnel. — Year 4

(2) Evaluate pilot project and apply results to other areas. — Year 5

f. Subobjective: By the end of year 5, to have tested the impact of peer counseling and outreach on use of CHDP and other health services by Medi-Cal teenagers, through a peer counseling pilot research project.

2. Objective: By Year 3, 90 percent of first-grade enterers to be submitting either a certificate or waiver; by Year 5, 80 percent of first-grade enterers to be submitting screening certificates, and 70 percent of the school enterers eligible for state-paid health assessment to be receiving state-paid health assessments, as documented by PM 160s.

a. Subobjective: By Year 3, for 75 percent of the schools to be encouraging completion of CHDP requirements prior to kindergarten entry and using the kindergarten year to follow-up with children who have not received a health assessment.

In cooperation with the Department of Education and local CHDP programs, identify school districts not yet stressing prekindergarten health assessment and barriers to change, and initiate steps to get schools to change to pre-kindergarten health assessment. — Year 1

b. Subobjective: By Year 2, to increase CHDP outreach efforts by schools in 10 counties, by providing positive support to schools.

(1) Change the schools' annual CHDP report form to allow schools to earmark the CHDP reimbursement for school health services. — Year 1

(2) With the Department of Education, identify successful models and methods of CHDP/school cooperation. Make information available at the local level. — Year 1 and continuing

3. Objective: By Year 5, 40 percent of all general practitioners, family practitioners, and pediatricians to be functioning as CHDP service providers or providing information, with parental consent, to CHDP on preventive care given to target group patients.

a. Work with the American Academy of Pediatrics and California Medical Association to develop provider recruitment materials. — Year 1 and continuing

b.	Support and assist resource development activities 12/ in local EPSDT units.	Year 1 and continuing
c.	In cooperation with the American Academy of Pediatrics, California Medical Association, and other provider groups, identify resources and provide workshops and other assistance in private provider recruitment.	Year 1 and continuing

4. Objective: To support the availability of health education in California schools, including education about preventive care and other preventive health practices.

a.	Support Department of Education implementation of the Comprehensive Health Education Bill, if passed.	Beginning Year 1
b.	Support local school district implementation of the State Framework for Health Education and integration of education regarding preventive care into school curricula.	Beginning Year 1
c.	With the Dental Health Section, identify and inititate appropriate joint activities to support dental health education and disease prevention programs in schools.	Year 2

5. Objective: By Year 5, to have increased the health education component of the health assessment in 25 counties.

a.	Initiate consultation and other assistance to local CHDP programs in developing a nutrition education component.	Year 1
b.	Initiate clearinghouse function 13/ at the State for health education materials.	Year 2
c.	Cooperate with efforts of the Maternal and Child Health Branch to develop a statewide child accident prevention program.	Beginning Year 1
d.	With the Dental Health Section, develop dental education resources and materials for assistance to local CHDP programs.	Year 2
e.	Provide training to interested local CHDP programs in parent effectiveness counseling as part of health assessment.	Year 4

12/Resource development activities: activities designed to increase the number of CHDP health assessment providers.

13/Clearinghouse function: State to provide a central catalogue and samples of health education materials for the use of local CHDP programs.

6. Objective: By Year 5, to make training available to private physicians, dentists, and other health professionals in health education methods.

In cooperation with the American Academy of Pediatrics, the California Medical Association, State Child Health Board, California Dental Association, California Conference of Local Directors of Health Education, Society for Public Health Education, and local CHDP programs, design and implement training in health education methods.	Year 4

XI. Action Plan for Health Assessment

A. Problems and needs.

The main problems of the health assessment component of the program have been identified as follows:

1. Medi-Cal children currently receive preventive health care both through CHDP and through the regular Medi-Cal system. The care which takes place through the Medi-Cal system is difficult to assess, both as to quantity and as to comprehensiveness. This problem raises compliance issues with the Federal Government and leaves unanswered questions about the current unmet need for preventive care for Medi-Cal children.

2. Even with increased recruitment of existing health providers into the CHDP service network, health assessment resources are insufficient, due to lack of health resources in rural and other underserved areas and to inefficient use of existing health resources (e.g., underutilization of nurses, nurse practitioners, and health paraprofessionals).

3. CHDP services need to be made acceptable and accessible to families who have special needs. These needs include: evening and weekend clinics, neighborhood clinics, free or low-cost transportation, child care, bilingual and bicultural personnel, and more convenient and familiar screening locations.

4. There is concern about the lack of appropriate methods to adequately assess the emotional, behavioral, and developmental needs of the child.

5. Currently, Medi-Cal children establish eligibility for CHDP services through the use of the Medi-Cal card and POE stickers. Delays in families' receiving the card make timely receipt of CHDP services difficult.

6. Standards for the procedures to be included in a health assessment need to be updated, so that age-appropriate procedures are used.

7. Some teenagers do not use CHDP services currently because of requirements for parental consent, because the services are viewed as "children's" services, and for other reasons which make services unacceptable and unattractive to them.

8. Some local CHDP programs lack tools to monitor and improve the quality of performance of their own health assessment personnel. No formal methods have been developed to decertify an organizational health assessment provider who provides poor quality services.

9. The concurrent requirement for CHDP vision and hearing testing prior to school entry and for vision and hearing testing in the schools at kindergarten or first grade creates problems of reimbursement, duplication of services, and information flow.

10. The Program must be able to keep at the forefront of health care by testing new and innovative models of service.

B. Objectives and activities.

1. Objective: Beginning in Year 1, to address the problems created by Medi-Cal eligible children receiving preventive care through both CHDP and the Medi-Cal system, with the ultimate objective that all Medi-Cal children receive comparable high-quality preventive care and the extent of all preventive care provided to Medi-Cal children is known.

a. Intensive campaign to recruit physicians and other providers to provide preventive care to Medi-Cal children through CHDP, rather than through Medi-Cal.	Year 1 and continuing
b. Devise methods to allow institutional providers to use billing machines to bill CHDP and thus provide preventive care to Medi-Cal children through CHDP rather than Medi-Cal; in subsequent years explore automated billing for other high volume providers.	Year 1 and continuing
c. Provide incentives to private physicians and other providers to bill preventive care through CHDP, rather than through Medi-Cal: simplify forms, revise fees, provide training in use of forms and other aspects of the program, provide follow-up assistance through local EPSDT units.	Year 1 and continuing
d. Make computer print-outs available to local CHDP programs from the Medi-Cal system: (1) to identify duplicate service or duplicate billing through CHDP and Medi-Cal; (2) to identify services provided through Medi-Cal to Medi-Cal beneficiaries.	Year 1 and continuing

e. New Medi-Cal fiscal intermediary contract to require contractor to identify CHDP equivalent procedures billed through Medi-Cal and report procedures, dates, and provider to CHDP. — Year 3

2. Objective: In addition to recruiting existing health care resources into CHDP, to promote development of health care resources sufficient to meet an expanding demand for CHDP services throughout the next five years.

a. Provide or encourage financial and other support to the training of pediatric nurse practitioners. — Year 1 and continuing

b. Support and coordinate with the efforts of the Indian Health Section, Rural Health Section, Federal Government, and others to increase health resources in rural and underserved urban areas. — Year 1 and continuing

c. Through ongoing field consultation, identify opportunities to use existing public and private resources more efficiently and effectively by upgrading of skills, integration, and coordination. — Year 1 and continuing

3. Objective: By Year 1, to have revised program regulations and standards regarding the screening procedures to be provided at various ages. (Note: changes suggested during this planning process will be considered in revision of regulations.)

4. Objective: To add an appropriate developmental screening procedure to the CHDP health assessment at any time one becomes available in the next five years, through developing in Year 1 a method to monitor and evaluate developmental screening research. To provide training in the use of any procedure which is adopted and training in confidentiality and appropriate use of results.

5. Objective: By Year 2, to be providing more timely CHDP service to Medi-Cal children, through simplifying documentation of Medi-Cal eligibility for new Medi-Cal recipients who desire CHDP services.

6. Objective: By Year 3, to have used the evaluation and needs assessment process to identify unmet needs for weekend and evening CHDP services, transportation, convenient acceptable CHDP service locations, child care, and bilingual personnel.

7. Objective: By Year 3, to have solved the problems created by coexistence of the CHDP vision and hearing screening requirement and mandated kindergarten/first grade vision and hearing screening in the schools.

8. Objective: To have increased the percentage of Medi-Cal teenagers utilizing CHDP services by Year 3, through resolution of the question of teen consent to health assessment and support to local counties in developing CHDP services which are acceptable and accessible to teenagers.

9. Objective: By Year 5, to have increased the quality of health assessment offered through CHDP.

a. Organize task force to develop procedures for local program decertification of organizational CHDP providers who provide substandard care, as defined by CHDP regulations and standards.	Year 1
b. Integrate evaluation of the quality of the health assessment process into the evaluation program, including counseling on emotional, behavioral, and developmental needs.	Year 2
c. Develop tools for local programs to use to monitor quality of their assessment procedures on an ongoing basis.	Year 3

10. Objective: Beginning in Year 1, to utilize pilot projects to evaluate and prepare new service models for use in the rest of the State.

a. Initiate pilot projects in Contra Costa and Sonoma Counties to establish cost, feasibility, and impact of screening low-income infants.	Year 1
b. Initiate pilot project to demonstrate feasibility of integrating CHDP with other teen health services (family planning, VD, etc.)	Year 3

XII. Action Plan for Referral and Follow-Up

A. Problems and needs.

In January 1977, a sample survey of the CHDP Program found that 70.6 percent of the Medi-Cal children sampled who needed referral for diagnosis and treatment actually completed the referral. In approximately eight percent of the cases requiring follow-up, referral was refused by the parent. Based on previous studies, the rate of completion is likely to be lower for the school enterers who received state-reimbursed health assessment.

Barriers to completion of referrals include the following:

1. High population mobility (e.g., one-third of the population of Los Angeles County moves every year).
2. Parents lack adequate financial resources.
3. Lack of diagnostic and treatment providers:
   a. Rural areas lack health care resources.
   b. In some areas, providers refuse to accept Medi-Cal patients.
4. Parents fail to understand the need for diagnosis and treatment or they resist accepting the assessment result.
5. Support and assistance to help parents complete referrals may not be available, or, if available, the potential follow-up support system is inadequately coordinated or expensive to coordinate (physician, CHDP, schools, social services, day care centers, etc.)
6. Inadequate tracking and case review systems.
7. Lack of transportation.
8. Confusion at the local level regarding Crippled Children Services, Medi-Cal, and Denti-Cal coverage and eligibility.

B. Objectives and activities.

1. Objective: Within five years, to achieve an 80 percent sucess rate for completed referrals. (Assumes 10-20 percent of children will be lost to follow-up due to moving.)

   a. Subobjective: By Year 4, to have reduced noncompletion due to financial barriers.

(1)	Gather data to identify specific needs for diagnosis and treatment funding.	Year 1 and continuing
(2)	In cooperation with other Department of Health programs, develop proposals to provide funding and appropriate funding channels.	Year 2
(3)	Support allocation of funds for 1980-81.	Beginning Year 2

   b. Subobjective: By Year 3, to have improved follow-up methods, referral tracking systems, and case review activities, in cooperation with the Social Services Division.

(1)	Support development of referral and follow-up activities in EPSDT units.	Year 1
(2)	In cooperation with local CHDP programs and welfare departments, identify minimal data needed for the referral system and identify successful follow-up methods, tracking systems, and case-review methods in use at the local level.	Year 1 and continuing
(3)	In cooperation with local CHDP programs and welfare departments, design prototype tools for follow-up and tracking. Make available for local use and adaptation.	Year 2

c. Subobjective: By Year 3, to have developed new resources for follow-up nutrition and obesity counseling in five counties.

(1)	Identify strategies which local CHDP programs can use to secure resources (e.g., training of existing personnel, outside grants for program development, unknown existing resources).	Year 1 and continuing
(2)	Initiate consultation and assistance in resource development.	Year 1

d. Subobjective: By Year 2, to have increased appropriate local CHDP Program coordination with and utilization of Medi-Cal, Denti-Cal, Crippled Children Services, and other resources for financing and assistance in follow-up, through workshops and consultation.

e. Subobjective: By Year 5, to reduce the number of outside referrals 14/ by increasing the number of comprehensive care providers and encouraging screening only providers to give at least a minimum of follow-up care (anticipates CHAP requirements).

(1)	Active campaign to recruit private physicians as comprehensive care providers.	Year 1 and continuing
(2)	Initiate cooperative Department of Health assistance to local CHDP programs in developing the diagnosis/ treatment capacities of "screening only" providers (e.g., training and consultation in program development, development of prototype linkage agreements).	Year 3 and continuing

14/Outside referrals: referrals beyond the health assessment provider for purposes of diagnosis and treatment.

f. Subobjective: By Year 2, to have increased follow-up resources in five counties through cooperative work with the Rural Health Section to identify rural health projects with potential for follow-up care.

g. Subobjective: By Year 5, to have increased the role of professional schools in assigning students to provide diagnosis and treatment in rural areas as part of their clinical preceptorships.

(1) In cooperation with other programs (e.g., Rural Health Section, Contract Counties Services Section), identify specific needs. — Year 3

(2) Cooperatively develop strategies for involving professional schools. — Year 3

(3) Initiate joint contact with schools to explore possibilities. — Year 3

(4) Facilitate initiation of services. — Year 4

2. Objective: To decrease the percentage of patent follow-up refusals by Year 5.

a. Cooperate with the Social Services Division to identify successful methods of coordinating community resources (CHDP, Social Services, physicians, schools, day care center, etc.) to assist and support parents in follow-up. — Year 2

b. With Social Services, provide assistance on request to local programs in implementing new methods. — Year 3

XIII. Action Plan for Integration and Coordination of Child Health Services

A. Problems and needs.

There is general agreement that if child health services were better coordinated and integrated, children would be better served. Some barriers to coordinated/integrated child health services are:

1. Categorical funding and regulation. 15/

2. Lack of focus or responsibility for achieving integration.

15/Categorical funding and regulation: refers to the existence of multiple independent child health programs with varying eligibility standards where use of money and program activities are restricted to very specific and narrow problems (e.g., lead screening, nutrition, immunization) rather than having a single program which is able to deal with the "whole child" and respond to varying individual needs.

3. Lack of models for integration.

4. Need for a variety of local solutions to meet local needs.

5. Lack of knowledge by program people at the state and local levels regarding related services.

6. Difficulty for state staff in understanding impact of decisions at the local level.

7. Lack of consumer impact on services.

8. Lack of resources to pursue integration/coordination.

In providing CHDP services to the Medi-Cal population, coordination between local health and welfare departments is essential. In order to support local activities, coordination must be vigorously pursued at the State between the CHDP Branch, Social Services Division, Medical Assistance Division, and Department of Benefit Payments. Until the current year, resources for achieving coordination were scarce. Now that resources are available, consultation, information, and other assistance must be provided by the State to local health and welfare departments in a coordinated way, so that EPSDT units and local coordination continue to develop effectively.

B. Objectives and activities.

1. Objective: To provide state support to local health and welfare departments in coordinating CHDP services to the Medi-Cal population.

a. Joint work by CHDP Branch, Social Services Division, Division of Medical Assistance, and Department of Benefit Payments through the CHDP Coordinating Committee, to interpret federal requirements, develop consistent regulations, and establish policies and procedures supportive of local health and welfare department coordination.	Year 1 and continuing
b. Joint work by state CHDP and Social Services field staff to provide consultation to local health and welfare departments on development, implementation, and evaluation of expanded working agreements.	Year 1 and continuing
c. Joint monitoring by the CHDP Coordinating Committee of the use and impact of the EPSDT allocation in local health and welfare departments.	Year 1 and continuing

2. Objective: Beginning in Year 1, to participate in the development of a committee on integration and coordination of child services within the Public Health Division.

a. Establishment of a Divisional Child Services Coordination Committee.

b. Staffing for the committee.

c. Mechanism for input from consumers and local health departments.

d. Development of objectives and work plan. Suggested agenda to include integrated program budgeting, pooling of special state consultants (each to provide assistance to fewer counties but cover a wider range of programs/services), coordination with school health programs, coordinated child health outreach, and integrated reporting forms and requirements.

3. Objective: Beginning in Year 1, to participate in the development of a committee on integration and coordination of child health services within the Department of Health.

a. Establishment of functioning Child Health Services Committee within the Department of Health, with the goal of integrating child health services within the Public Health Division, Social Services, and Developmental Services.

b. Staffing for the Child Health Services Committee.

c. Mechanism for input on integration from consumers and local health departments to the committee.

d. Development of objectives and a work plan.

4. Objective: By Year 2, in cooperation with the Department of Education, to have identified and implemented mechanisms to coordinate the work of CHDP and the Immunization Assistance Program (IAP) as it relates to schools and to have identified ways to productively share IAP and CHDP resources at the state and local levels.

5. Objective: By Year 3, to test the feasibility of models to integrate State Division of Public Health funding for child health services in local health departments.

a. Allow CHDP allocation on the basis of an integrated child health services plan. Year 1

b. Identify Division of Public Health programs interested in testing joint funding of local programs on the basis of an integrated child health services plan. Year 2

c. Develop pilot project mechanisms and support. Year 2

d. Initiate pilot project. Year 3

6. Objective: By Year 4, to have assisted in the development of an effective, staffed child health services council in ten counties with the purpose of coordinating and integrating local child health services and advising the State Child Health Services Committee and Divisional Child Services Coordination Committee regarding integration and coordination at the state level.

   a. Department of Health and California Conference of Local Health Officers (CCLHO) identification of existing models and potential resources. — Year 2

   b. CHDP to participate in cooperative consultation and other assistance to counties, including consultation on funding alternatives such as Health Systems Agency sponsorship, cooperative State Department of Health funding through integrated child services budgeting (see pilot project above), or other mechanisms. — Year 2

7. Objective: During the next five years, to encourage an adequate number of school nurses who will act as coordinative agents in the school setting for all health care resources and who will provide other school health services.

   a. Revise the annual CHDP school reporting form (PM 272) to allow schools to earmark the CHDP reporting reimbursement for school health services. — Year 1

   b. Identify and initiate strategies to encourage school district support of school nursing services. — Year 2 and continuing

   c. Participate in a Department of Health review of its role in support of school health and nursing services, including financial support. — Year 3

XIV. Action Plan for Administration and Management

A. Problems and needs.

1. CHDP's method of allocating funds to local CHDP programs needs to be revised to provide incentives for good program performance and to more equitably provide for varying local program needs and costs.

2. No formal management and fiscal audit plan by the CHDP Branch has been made and no resources have yet been dedicated to this function.

3. No fiscal and administrative manuals for county staff guidance have been developed, hence county plans and budgets are not consistent nor are they always focused on performance goals and measurable objectives.

Objectives and activities.

1. Objective: By the end of Year 1, in cooperation with local programs, to have developed a Fiscal/Budget Procedures Manual, including a model and format for budget development and budget revision procedures.

2. Objective: By Year 2, to have developed preliminary measures of local program performance and workload.

   a. In cooperation with local programs, identify methods of evaluating programs through performance standards and workpads in the four areas of their program: administration, outreach, health assessment, and follow-up. — Year 1

   b. Implement a system whereby counties will report using these program and workload measures. — Year 2

3. Objective: By Year 4, to have fully developed fiscal and management capabilities for review of local CHDP programs.

   a. Revise state instructions on local budgeting and claiming consistent with "Accounting Standards and Procedures" of the State Controller's office. — Year 1

   b. Begin developing the elements of an auditing manual. — Year 1

   c. Develop reporting procedures for recording CHDP funds in special CHDP revenue accounts on the county level in accordance with the "Uniform Accounting Standards and Procedures" required of counties by the State Controller. — Year 2

   d. Provide state assistance to counties to implement the accounting procedures. — Year 2

   e. Begin auditing counties on a scheduled basis. — Year 3

4. Objective: Beginning in Year 2, to readjust the local CHDP program allocation method so that allocations are determined by factors, including performance criteria, generally acceptable to the state and local programs.

a.	Establish a county-state staffed local CHDP Program Advisory Committee to review allocation indicators, and propose changes in allocation methods.	Year 1
b.	Make changes in local program allocations, based on the committee's recommendations.	Year 2
c.	Continue to refine allocation methods, working with local CHDP programs.	Years 3, 4, and 5

XV. Action Plan for Evaluation and Planning

A. Problems and needs.

In the areas of evaluation and planning, the following problems and needs have been identified.

1. In the past, CHDP has had insufficient resources to develop an evaluation program. Data are needed to demonstrate program achievements. Untabulated data are currently available and should be collected, tabulated, and analyzed.

2. Management information systems have never been fully developed. The systems should:

   a. Support program evaluation and monitoring.

   b. Allow tracking of individuals from health assessment through treatment.

   c. Utilize simple forms and procedures.

   d. Be used to develop baseline data on the health of children.

3. CHDP cannot adequately identify children served by other health care systems (e.g., Medi-Cal providers and other private providers) and children unserved by any system.

4. Local CHDP programs have had difficulty in supporting the development and implementation of routine and in-depth evaluation systems.

5. Several populations with special needs have been identified as possibly being inadequately served by CHDP. These populations include: teenagers, children and teenagers with developmental needs, migrant children, children in foster care/detention/protective services, children in day care, children served by special health facilities (Indian health clinics, neighborhood health centers, rural health clinics, free clinics). The unmet preventive health care needs of these populations should be identified.

6. Some problems have been identified which would require research on a sample basis to resolve. These problems include: effectiveness of screening procedures, detailed cost analyses, methods of outreach, etc.

B. Objectives and activities.

1. Objective: In Year 1, to develop data on current CHDP health assessment services, problems identified, and referral outcomes.

2. Objective: To develop management data and claiming systems which meet program needs for tracking individuals from health assessment through diagnosis and treatment, support program evaluation and monitoring activities, and produce child health information for statewide and local health planning.

a.	Establish Data System Advisory Committee.	Year 1
b.	Interface the CHDP system with Medi-Cal to allow tracking via patient profiles of children receiving health assessments from CHDP and treatment from Medi-Cal providers.	Year 1
c.	Modify forms used by CHDP health assessment providers.	Year 1
d.	Develop [illegible] system and automate the claiming [illegible] to produce a payment tape.	Year 2
e.	Enter referral information into the systems and report referral linkage.	Year 3
f.	Interface with new Medi-Cal fiscal agent to:	Year 3
	(1) Identify screens performed through Medi-Cal.	
	(2) Link EPSDT diagnostic and treatment services with CHDP and Medi-Cal health assessments.	
g.	Interface county computer systems with the CHDP automated system.	Years 1-4
h.	Interface with information systems for other child health related programs (Rural Health, Department of Education, Family Planning, WIC, etc.) to obtain broader based information on child health and, where feasible, integrate reporting forms and procedures.	Year 5

3. Objective: By Year 2, for the State CHDP Program to be able to provide consultation to local programs on the basis of a comprehensive picture of the relationship between CHDP, the existing local health care system, and unmet CHDP service needs, and for local CHDP programs to be able to use data gathered in cooperation with the State to plan for CHDP services and integration of CHDP into the local health care system.

a. In cooperation with the Data System Advisory Committee design an evaluation/needs assessment tool which can be used by the State at the local level to provide a broad picture of the local child health care system, the impact of CHDP, the relationship of CHDP to other health resources, and unmet CHDP service needs.	Year 1
b. Pilor test the evaluation tool and revise.	Year 1
c. Provide orientation to all local programs on the evaluation tool and how to use the results of the tool.	Year 2
d. Initiate routine use of the tool.	Year 2
e. Initiate the integration of annual local program plans with the evaluation program.	Year 2

4. Objective: By Year 3, for 50 percent of local CHDP programs to be doing local ongoing basic evaluation and needs assessment which is integrated with state evaluation activities.

a. In cooperation with the county-state staffed Data System Advisory Committee, develop materials and tools for optional use by local CHDP programs.	Year 1
b. Initiate training and consultation to local CHDP programs in use of the materials and tools.	Year 2

5. Objective: By Year 3, to have identified unmet CHDP service needs and strategies for intervention for the following populations with special needs: migrant children, children served by special health facilities (Indian health clinics, rural health clinics, neighborhood health center, free clinics), children and teenagers with developmental needs, children in protective care/foster homes/detention, children in day care.

6. Objective: By Year 4, to have implemented sample studies to evaluate more complex activities, outcomes, and problems, e.g., changes in health behavior, detailed cost analyses, evaluation of screening procedures, etc.

a.	Identify special problems requiring sample research studies.	Year 2
b.	Design studies with highest priority.	Year 3
c.	Implement special studies.	Year 4

Mr. SCHEUER. Dr. Bruyn.

STATEMENT OF HENRY B. BRUYN, M.D.

Dr. BRUYN. Yes, for the record, I am Dr. Henry B. Bruyn, and I'm here as an individual and as clinical professor of pediatrics and medicine at the University of California. I am also director of the local child health and disability prevention program and that is with the department of public health.

I would like to speak to the point that your bill needs EPSDT and the groundwork that it has laid. I think that you, yourself, Mr. Scheuer, described EPSDT as a disaster. I think it's——

Mr. SCHEUER. Well, its implementation was a disaster. I think the bill was fine.

Dr. BRUYN. Well, I don't want to throw the baby out with the bath water——

Mr. SCHEUER. Me, neither.

Dr. BRUYN. And I want to emphasize that point, then. EPSDT—the aims and goals were never clearly established and I think that very early on, we got swept up in the "S" part of EPSDT—the screening part, and compliance requirements led us around the Nation to try and create numbers of kids screened and that seemed to be the target for everybody's attention and effort. I don't think that was the basic intent of the bill. I think that EPSDT was a major national commitment to preventive health care which was without precedent and I think it was amazing that the Nation put that through as a Federal program. Certainly, as it was carried out, problems became apparent and remained.

California's CHDP program certainly carries out the health assessment activities required by EPSDT. It gives money to each county to promote EPSDT, as well as the basic health assessment of all children going to any kind of school for the first time.

In San Francisco, we made two basic assumptions in setting up our CHDP program in 1974 which are assumptions that can be made, I think, in a large part of the country. I don't think they can be generalized, but I don't think San Francisco is unique. Those assumptions established in 1974 were that we had medical resources in the city, including private physicians, prepaid clinics, and medical schools and public health department programs. That was one principle. The second was that we looked upon CHDP-EPSDT as an opportunity for referral of children through the screening procedure to a source of comprehensive continuous health care supervision that would contribute to long-term improvement and more healthy life. We had health resources in the community, so we tried to avoid the trap of screening, for its own sake, and tried to refer them to comprehensive, continuous care.

There seems to be no disagreement in the findings in health care research and the statements from organizations, that you are probably familiar with, Congressman, that continuous and comprehensive care contributes to good health.

It also can contribute a significant reduction in laboratory costs and hospitalization and so on. We took on the goal of linkage for these children to a comprehensive health care resource. In 1975,

nationally, we find that this was not taking place—1975, is when I have data. Fifty-eight point eight percent of all the screenings done in the United States were being performed in health departments, which, I feel, are not resources for comprehensive continuous health care in the high quality that is needed.

Mr. SCHEUER. What do you mean by "health departments"?

Dr. BRUYN. Well, like a clinic sponsored by the health department, held in a school, on Wednesdays and Fridays or a clinic established in a trailer van that moves around. Now, I have no doubt that such things are often necessary in rural areas and in some areas where continuous comprehensive health care providers are not available.

Mr. SCHEUER. Yes.

Dr. BRUYN. But I don't think it's high quality. We should all admit that. In setting up our program, as a major outreach effort and health education effort, we, incidentally, have built in such things as nutrition education. We tried to promote this through the providers, by giving them material on how to assess nutrition and how to teach nutrition.

We set up the following functions which were: (1) Intensive informing about health assessment and the value of comprehensive continuous health care, presented at the time of application for welfare benefits. This includes followup to assure that the children successfully enter that health care system upon the completion of their health assessment.

(2) Assurance of followup and followthrough by providing assistance to parents unfamiliar with the use of the health care resources in the city. This includes assistance to health care providers in outreach to their patients to assure necessary followup and return visits for recommended health care.

(3) Assurance of cooperation and effective delivery of high quality comprehensive continuing health care by the providers of health care in the city, including private physicians, prepaid health plans, institutions, and the department of public health clinics. That echoes something Dr. Shinefield has stated; that we find in this city and, I think, elsewhere in the State, that if we get out there and talk with providers, talk with the parents, and get people in there as protagonists, this goal can be reached.

(4) Is the development of an information system and a trained staff to serve parents, institutions, and health care providers, in coordinating the health care resources in the city. A city like San Francisco, and I have no doubt that it is familiar to you also in New York, is loaded with a tremendous collection of health care providers, covering all sorts of health problems.

In research projects, which I have done, now, for several years, in San Francisco, we have come up with a pattern of child health care that I think is probably as valid as any survey research project can be. The pattern of child health care, in a metropolitan area like this, is one of fragmentation, particularly for the poor, in which they find themselves using emergency rooms for their crisis intervention, if you will.

Mr. SCHEUER. Well, really, for their primary health care as well.

Dr. BRUYN. Often for their primary health care.

Mr. SCHEUER. They don't have a family doctor.

Dr. BRUYN. Well, family doctors are available, in a place like this; less than 3 percent of the medicaid eligible parents found any difficulty in finding a private physician, in our survey samples. So that in this area, they can have the private physician, but they need health education. They need to be guided. So, by way of conclusion, your H.R. 1702, it seems to me, would expand the benefits of medicaid to the entire population of children and pregnant women in this country and it is clear that such a massive expansion will create a massive challenge in health education and outreaeh. It is, at this point, I feel that EPSDT, and in particular California's improvements on EPSDT through what we call CHDP, will fit in very beautifully with any program, such as health insurance for mothers and children, as an outreach in health education emphasis. Thank you.

Mr. SCHEUER. Yes, Dr. Cunningham.

Dr. CUNNINGHAM. I just want to elaborate on two points very quickly. One is in regard to the role of the health department. Health departments do not provide comprehensive care, but they do provide a very high volume of preventive care. About 1 out of every 10 children, gets some kind of a service or immunization from a county operated piblic health clinic. They don't get acute episodic care. They don't care for chronic illnesses, but they do nutrition counseling, weighing and measuring, parental guidance—they do do early prenatal care, they do provide family planning—large volumes of family planning services, and so they do fulfill a role, which takes a burden off of the primary practitioner, who is skilled in providing those other kinds of services. So I think that that's the system that exists throughout the country. I've been out visiting in a number of States and, whether you are talking about parishes in Louisiana or counties in Iowa, they have district or local agencies who are, you know, on one or another governmental payroll, where they hire physicians and nurses to deliver this kind of care in organized settings.

So, in construeting your system, you should recognize that that's a base of preventative care that needs to be built on.

The other point I would like to correct is the fact that, while in San Francisco, which is rich with resources, physicians are available in many areas of California, they are not available. We have a very crisis situation and I am predicting that we will have an increase in our infant mortality as a result of this, in that we've had a malpractice crisis which raises the general practitioner's malpractice fees from something like $7,000 a year to something like $27,000 a year, if he does more than 10 percent of his practice in obstetrics. That means that he is going to wipe it out. He's not going to do the 20 to 40 deliveries that he does.

(2) The medicaid program pays him totally for the whole 9 months of care and the hospital delivery, something like $300 when the going rate is from $400 to $700. As a result, they say, "Who needs it?" "I can make enough from private patients."

We have given that woman a medicaid card, an entitlement, in a county where she has to travel 160 miles before she finds a doctor who is willing to take her.

The other question is: What kind of doctors end up taking them? Sometimes they are not the very best doctors. We've done studies of infant mortality in county hospitals, where medicaid is paid for—a

woman who is toxemic with high blood pressure, being seen by a general practitioner with no special training in obstetrics, who when she gets into serious trouble is referred into the county hospital and loses the baby.

So these are the kinds of problems that are inherent in the medicaid system. Entitlement does not entitle you—because we have no mandate that physicians have to participate in any program—your program or our program, or any other program. That has been a serious problem.

Dr. BRUYN. I might echo a point that Dr. Breslow made some time ago and I think he would allow me to paraphrase it, and Dr. Cunningham's point raises it, too.

The availability of the provider is, very often, dependent upon the financial relationships that he is able to establish. Dr. Breslow made the point that no health care system, third-party payment system, could possibly survive unless it met the market place as far as fees are concerned. In California, when the EPSDT program first started, a fee of something like $12 for a complete history and physical, amazingly enough, did not attract the independent providers and the result was that it was similar to what Dr. Cunningham describes in the obstetrician's problem. They are driven right out of the system when they are paid a fee like that.

Mr. SCHEUER. Why do you say, "amazingly enough"?

Dr. BRUYN. I'm being sarcastic.

Dr. SHINEFIELD. I think that's terribly important. Now, if the money is to be realistic, the fees must be realistic.

I think that the other point which Dr. Cunningham made is very important, too, that the fees will help get us the providers in certain doctor-rich areas and in other areas, we'll have to have other providers. California is a microcosm of the United States, really. We have the rural problem. We have the farming problem. We have the—we have all the problems. The way to meet—we would—that's the flexibility that we are talking about, that becomes so terribly important and recognizing that. The nurse practitioners are terribly important in delivery of these services. We're utilizing the county health departments, so that, again, this kind of flexibility becomes terribly important and a need to get everybody aboard and the need to get everybody involved and make them protagonists of the program and to find out their problems and help solve them. Money is certainly an important one of them. It isn't the only one. We can't neglect that because if you neglect that and deal with moral rights and all the incentives—let's get to real—to the incentive situation.

Mr. SCHEUER. OK. Thank you very much. This was an absolutely terrific panel and I'm grateful to all three of you.

[Dr. Bruyn's prepared statement follows:]

STATEMENT BY

HENRY B. BRUYN, M.D.

Clinical Professor of Medicine and Pediatrics, University of California, San Francisco and Director of Child Health & Disability Prevention, Department of Public Health, City and County of San Francisco

The Early Periodic Screening Diagnosis and Treatment Program (EPSDT), passed into law in 1967, has been described as a failure. The aims and goals of this law were not clearly established, and its application throughout the United States has varied markedly from state to state and county to county. In California, the Child Health and Disability Prevention Program was established by legislative act in 1974. This act provided for the allocation of money to each county in the state to establish programs which would carry out the health assessment activities required by EPSDT but most importantly this state law also established a general health assessment as a requirement for enrollment in all schools of California at the level of first grade. It was the intent of the legislation to allow each county a great deal of autonomy in the ways in which they developed their programs. It is quite apparent that throughout the State the patterns of child health care vary so widely from one county to the next that local autonomy in this regard is extremely important.

One of the basic principles upon which the CHDP - EPSDT program in San Francisco was established in 1974 was the assumption that the City and County was well endowed with medical resources, including private physicians, pre-paid health plans, clinics, medical schools, and public health programs. A second basic principle guiding our program since its beginning was that the screening procedure or health assessment would represent an opportunity for referral of children with potential problems to appropriate community resources and, in particular, resources which would provide continuing medical supervision and future health evaluations. There seems to be no disagreement in the findings of health care research and in the statements and guidelines published by responsible organizations such as the Academy of Pediatrics that, when health care for children is continuous at one resource, problems are detected at an earlier stage because of familiarity with the patient and the parents. A regular relationship with one health care resource, providing continuous and comprehensive care, can contribute to a significant reduction in laboratory costs, prescription medications, hospitalizations, operations, and illness visits.

The goal of linking children to continuous comprehensive health care was not stated in the original EPSDT legislation. Experience around the Nation and also in California shows that such comprehensive continuous health care supervision is not always available to Medicaid eligible families from existing community resources. It is also apparent that many states focused their EPSDT programs primarily on public health department clinics. In 1975, 25 states screened children primarily in health department clinics which certainly could not be considered as sources of comprehensive continuous child health care. In 1975, 58.8% of all screenings done in the United States were performed in health departments. Reports to the Academy of Pediatrics indicate that in some states children were referred to health departments for screening even if they had a regular source of health care for their children.

The San Francisco CHDP - EPSDT program concentrated its efforts during its first two years on the promotion and development of the many health care resources potentially able to meet the needs for continuing medical supervision and future health evaluation. Two research projects were carried out on the patterns of child health care as they existed in this city. These research projects showed that the many health care resources in the city had created a pattern of child health care which was often fragmented for the poor into multiple resources for each child. Incoordination and duplication of roles among many agencies and bureaucracies was commonly found. It was concluded that the major function of the program was that of health education and coordination through outreach throughout the community. An enhanced outreach effort is underway comprising the following functions:

1. Intensive informing about health assessment and the value of comprehensive continuous child health care, presented at the time of application or reapplication for welfare benefits. This includes follow-up to assure that children successfully enter the health care system through completion of the health assessment.
2. Assurance of follow-up and follow-through by providing assistance to parents unfamiliar with the use of the health care resources in the city in ways which

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contribute to the best interest and health of their children. This includes assistance to health care providers in outreach to their patients to assure necessary follow-up and return visits for recommended health care and health assessment.

3. Assurance of cooperation and effective delivery of high quality comprehensive continuing health care by the providers of health care in the city including private physicians, pre-paid health plans, institutions, and the Department of Public Health.
4. The development of an information system and trained staff to serve parents, institutions, and physicians which will provide advice and referral to general and special health care resources throughout the city.

Data from the San Francisco Program in the year July 1, 1976 thru June 30, 1977 demonstrates the early realization of our basic goal. During this year, 6,213 reports from health assessment of children were filed. Of these reports, 65% came from private physicians and 18% from private institutions and clinics providing continuous comprehensive health care. The Health Department accounted for only 17% of the total reports received. 33% of the children were referred for diagnosis and treatment for some condition found on health assessment. This includes referral for dental care, but it is apparent that policy for such referral varies widely at the present time among health care providers, some of whom refer 100% of children at a certain age while others advise the parents and do not make a formal referral.

The California CHDP Program has had its impact in many areas of the state on the Medicaid eligible children and families in improving the quality of health care supervision during childhood. Through the requirement for health assessment at the time of enrollment in first grade in schools, the program bas undoubtedly had an impact on many children not eligible for Medicaid. The National Health Insurance for Mothers and Children Act (HR 1702) would expand the benefits of Medicaid to the entire population of children and pregnant women. It is clear that such a massive expansion will create a massive challenge in health education and outreach. The

CHDP Program in California and the EPSDT Program nationally would seem to be a most effective foundation for the necessary coordination health education and outreach to assure that high quality comprehensive continuous health care is available to the children of the Nation.

Mr. SCHEUER. We will now recess, to return at 12:30.

[Whereupon, at 12:15 p.m., the subcommittee was recessed for lunch until 12:30 p.m. of the same day.]

AFTER RECESS

[The subcommittee reconvened at 12:30 p.m., Hon. James H. Scheuer, presiding.]

Mr. SCHEUER. Our next witnesses are Barbara Durand, Jane George, and Virginia Fowkes.

Is there any particular order in which you have decided you would like to proceed?

Ms. DURAND. No, we haven't.

Mr. SCHEUER. All right. Why don't we go in alphabetical order, Barbara Durand first, Virginia Fowkes second, and Jane George third, OK?

Ms. DURAND. That would be just fine.

I have a brief statement—and it is brief—that I would like to read and then I will be happy to answer any questions.

Mr. SCHEUER. All of your statements will be printed in the record, so rather than read them, why don't you just talk to us?

Ms. DURAND. All right.

STATEMENTS OF BARBARA DURAND, ASSOCIATE CLINICAL PROFESSOR OF NURSING AND CODIRECTOR, PEDIATRIC NURSE PRACTITIONER PROGRAM, UNIVERSITY OF CALIFORNIA, SAN FRANCISCO; VIRGINIA FOWKES, DIRECTOR, PRIMARY CARE ASSOCIATE PROGRAM, STANFORD UNIVERSITY, CALIF.; AND JANE GEORGE, ASSISTANT ADMINISTRATOR, ALTA BATES HOSPITAL, BERKELEY, CALIF., AND MEMBER OF ADVISORY BOARD, EAST BAY CHILD-BIRTH RESOURCE CENTER

Mr. Chairman, I am Barbara Durand, and I have been a pediatric nurse for 18 years. I have worked as a staff nurse in pediatrics, as a clinical specialist in pediatric nursing, and as a pediatric nurse practitioner. I am currently associate clinical professor of pediatric nursing at the University of California here in San Francisco. I have been teaching in our pediatric nurse practitioner program for the last 7 years. I am currently codirector of that program (see p. 314).

This is a program that is operated jointly by the school of medicine and the school of nursing. Also, in addition to teaching, I am engaged part-time as a nurse practitioner in pediatrics providing primary health care services to a group of families with young children.

Mr. SCHEUER. Primary health care?

Ms. DURAND. Primary health care in the pediatric program at the medical center. What I wanted to address to you in my remarks today were some features of the role of the nurse practitioner in primary health care in order to assist you and your committee in forming manpower policies, and in its consideration of reimbursement policies for qualified providers of primary health care services.

I think that the development of the nurse practitioner role has been of major significance in providing for the appropriate utilization of

professional nursing skills in the delivery of child health care. The additional training that a nurse practitioner receives is built on previous nursing knowledge, and enables them to be responsible to provide direct patient care services in ambulatory settings. I think the impact that it has had can be summarized by the fact that nurses are now managing children and families rather than the environment, the system, and the equipment.

A full description of the functions and responsibilities of pediatric nurse practitioners was developed in a joint statement published in 1971 by the American Academy of Pediatrics and the American Nurses' Association. It was a landmark, document in its time because it was the first such document to be developed between organized medicine and organized nursing. I would like to quote one paragraph from that statement, because I think it is of particular note. It addresses the overlapping of nursing and medical functions and also the issue of the independent role of the nurse in providing such functions, which is key to some of the gist of my testimony. That paragraph is:

> The expansion of the nurse's responsibilities would encompass some of the areas that have traditionally been performed by physicians. Proficiency and competence in performing these new technical skills associated with the expanded responsibility should be viewed as increasing the sources from which the nurse gathers data for making a nursing assessment as a basis for diagnosis and action and thus contribute directly to comprehensive nursing.
>
> Nurses must therefore be prepared to accept responsibility and accountability for the performance of these acts and must have the opportunity to be engaged in independent as well as cooperative decision making.

Inherent in that statement is recognition of the nurse as an independent practitioner of nursing in the delivery of health care. Nursing, in California and many other States—I think there are now about 42 States that have modified and redefined what the legal definition of nursing includes—it has been redefined legally to recognize that medical and nursing functions do overlap and to permit for additional sharing of functions between nurses and physicians in a collaborative way.

My own philosophy, the philosophy of our program, and that of all nurse practitioners that I know, is that primary health care is a cooperative enterprise. Nurse practitioners are not physicians and must consult with, refer to, and collaborate with physicians when medical problems arise.

Mr. SCHEUER. Do they function under the supervision of a physician at all times under your law?

Ms. DURAND. That is an issue. According to the law as defined, and I have attached a copy of the California Nurse Practice Act to the testimony (see p. 316), because it has been held as an exemplary model of how such redefinition of nursing practice could be written. The law encourages cooperation.

It permits the performance of some specific preventive health functions without supervision, but in those areas where functions overlap it calls for the establishment of protocols and procedures that are mutually agreed upon by physicians and nurses. In just a moment, perhaps, I will speak more to the issue of direct supervision in the performance of all health functions of the nurse practitioners.

Mr. SCHEUER. Have the pediatricians, individually and collectively, felt threatened by this growing field of nurse practitioners delivering counseling service and preventive health service independent of the pediatrician?

Ms. DURAND. There are two issues involved there. Pediatricians were the first of any recognized specialty within medicine to invite the participation of nurses in the performance of these services, for which I commend them, and it reaffirms, to me, what was mentioned earlier this morning, that they are a unique group of medical practitioners.

Mr. SCHEUER. In other words, it wasn't just a reluctant acquiesence in accommodating themselves to the inevitable?

Ms. DURAND. I don't believe that it was, and I think the statement that I quoted from mentions the philosophy that includes collaboration and not just somebody to do what they didn't have time to do. It really recognized, I think, some other dimensions of care. I think——

Mr. SCHEUER. Can you give us a copy of that statement.

Ms. DURAND. I certainly can. I think that the notion of nurses practicing independently is another issue. I cannot speak for pediatricians; I can speak of my interpretation of their stand on this and I suspect that they do not support the private or independent practice of health care by nurses.

Mr. SCHEUER. Even if that health care is confined to just counseling and preventive health care?

Ms. DURAND. Well, I don't know. That would be my philosophy, that this should be possible, if it is legally sanctioned and within the professional scope of practice.

Mr. SCHEUER. Is it legally sanctioned under California law?

Ms. DURAND. I interpret it as being so.

Mr. SCHEUER. That's not answering my question, but I guess that is the best you can do.

Ms. DURAND. Our laws have not been tested, and our interpretation is liberal, and I think that health education is an acknowledged and legally sactioned role of the nurse, which is why I say that in your bill, H.R. 1702, which I commend for its inclusion of preventive services, as covered services, that there are many of those services, the preventive children's health services, including assessment, immunizations, screenings, and particularly health education, that are within the purview of the nurse practitioner.

Mr. SCHEUER. I take it that you do, as a matter of practice under your interpretation, engage in independent counseling of mothers and advise them on every aspect of preventive health and health maintenance, diet, nutrition, exercise, and so forth? You do that?

Ms. DURAND. I do that.

Mr. SCHEUER. And you do that without the supervision of a doctor?

Ms. DURAND. I think the word supervision is——

Mr. SCHEUER. You are not under the direct supervision of a doctor?

Ms. DURAND. I work in collaboration with a physician.

Mr. SCHEUER. Where is the physician physically located when you are counseling?

Ms. DURAND. In my setting, the physician is on the premises.

Mr. SCHEUER. He is on the premises?

Ms. DURAND. Yes.

Mr. SCHEUER. Do you discuss with him what you are telling each mother and child or just in general what you tell mothers and children?

Ms. DURAND. At this point, and with my past experience and the kinds of clinical judgment that developed with training and experience, I consult with the physician when medical problems arise, and if there is a problem I am having trouble deciding what to do about we discuss it. The physician does not come into the room every time I see a patient. The patient belongs to my caseload, and I provide the care for the patient.

I am emphasizing this point in relation to H.R. 1702 for two reasons. In title II, part A, section 201 of subsection 2, the term "physician extender" is used to include nurse practitioners. I don't like that term. My dislike is not purely on a semantic basis; I think there are some substantive issues involved. Nurses are not new health workers. Nursing is an established profession and nurse practitioners provide services under the legal and professional scope of practice. Recent Federal legislation relating to rural health clinics' services have changed that terminology and specified nurse practitioners separately for those reasons.

The other point does relate to reimbursement policies. I would hope that distinctions between health care and medical care are recognized and that options be provided that would really permit utilization of services of qualified and legally sanctioned nurse practitioners.

Mr. SCHEUER. And that would allow you to be reimbursed independent of reimbursement to a physician?

Ms. DURAND. No, I will qualify that. The fact is that 99 percent of nurse practitioners are employed by agencies and physicians. There are approximately 12,000 nurse practitioners, by current estimate, of all types in the country. One percent of that number are practicing independent of another organized health system. The majority of that 120 individuals are psychiatric nurses, so that the instance of nurse practitioners providing health services removed from an organized system is negligible.

My philosophy and that of my colleagues in our program certainly is collaboration, whether it be direct reimbursement or reimbursement to the agency is not the issue I see within that system, but I do think that the services should be reimbursed. One of the barriers to practice and employment for nurse practitioners in the past has been that some carriers would not reimburse fully for nurse practitioner services and certainly the preventive services were not reimbursable and that is the forte of the nurse practitioner, in my opinion.

Mr. SCHEUER. That is the forte?

Ms. DURAND. Yes. On the other hand, I think the time might be now to consider some alternative forms of providing services that might involve direct reimbursement. I am thinking from my own experience in working with mothers and children that health education is where "it's at," if we are going to effect some change in the future. I can see nurses, nurse practitioners—there are those doing it now—who are providing educational classes for parents, prenatal classes, breast feeding classes, child rearing classes. I can see that

there, perhaps, should be some mechanism for allowing nurses to do this. They might work in association with a group of pediatricians or have pediatricians refer parents in their practice to educational activities of this kind.

That nurse is in the business of health education, which is a legitimate service. Another area that always impresses me as I work with young mothers and children is that somewhere in the vicious cycle of what happens when people have not had adequate parenting models themselves and are having difficulties in parenting their own children that these mothers and parents need help in how to nurture. I think if parents can learn to be competent and confident of their own parenting abilities, if we can teach them self-reliance in the care of their own children, that that might have enormous payoff down the road. Very few mechanisms for providing that kind of service and support are available. I think that nurses and nurse practitioners could create nurturing centers or an agency where parents who are having difficulty could come for the kind of support and teaching and modeling that they need. That might not necessarily in the future be within an organized health system as we know it today. But I think that to require direct physician supervision, physician's orders or physician certification that such services are necessary is restrictive, and I think might interfere with some of these more innovative and collaborative models for health care. What I am doing today is to ask you for consideration and support of such mechanisms that might really provide for complete utilization of the skills of professional nurses and nurse practitioners and also to applaud the bill, particularly those features that recognize prevention as legitimate.

Mr. SCHEUER. Can you give us any details? Can you give us some constructive suggestions?

Ms. DURAND. I would first of all suggest that the term "physician extender" be deleted. I object to it on substantive grounds. I recently heard someone equate the term "physician extender" with "hamburger helper," and that sort of says how I feel about that particular term. I don't know who invented it; I don't know why. I would love to know what went in to the coining of that particular phrase. The assumption in that phrase is that anyone who is termed a physician extender is filling a need, extending the services of a physician; someone who is lesser qualified to do the tasks that require more rigorous scientific training and medical judgment; a lesser qualified person who can pick up some of the pieces. They are extending the services of the physician and the assumption therein is that there are not enough physicians to do those services themselves. The assumption would go on, then, to the logic that if there is no longer a physician shortage, there is no longer a need for physician extenders. The fact is, in the last 10 years, I believe, or maybe less than that, that the number of graduates from medical schools has increased. If there is no longer a physician shortage one day, does that mean there is no longer a role for a physician extender? That is the conceptual problem that I see in the use of the term.

Mr. SCHEUER. What you are saying is that you are trained to do things that doctors are not trained to do in medical school?

Ms. DURAND. That's right.

Mr. SCHEUER. And that the whole preventive health education and the whole health counseling role is a role that doctors are not trained to do at medical school and there is nothing in their internship or subsequent clinical experience that qualifies them to do that, assuming that they had the time to do that in the first place?

Ms. DURAND. The focus of medical education certainly has been on diagnosis and cure. You may see nurses, physicians, physician's assistants and others doing similar things, but educational background and professional orientation affect the context in which one performs. You may use the same tools to collect data, to make assessments, but it is your educational background, your professional orientation, that determines how you use that data. In modern nursing today, and I think as a profession we certainly need to communicate this more to the public, it is very different than in the past. It is very family oriented, very health maintenance and prevention oriented—and community based.

Mr. SCHEUER. Are you talking about all nursing?

Ms. DURAND. I am talking about professional nursing education now. It has changed.

Mr. SCHEUER. More than physician education?

Ms. DURAND. I think so. I have had personal experiences with pediatric interns and residents with whom I work and with whom I consult. They will come to me for information on nutrition. They will come to me for suggestions on helping parents with toilet training or with difficult behavior problems. I applaud them for doing that. That is an area that I have had extensive training in, so that it works both ways. We use each other's skills. In terms of the bill, I think to require direct supervision as a qualification for reimbursement for provision of services could be restrictive in that sense. What I am asking, in summary, is that nurse practitioners and other providers be identified as such and not as physician extenders, and that you consider different options for providing services than under the direct supervision of a physician.

Mr. SCHEUER. All right. Now, let me ask Dr. Bruyn, who is still here, and Peter Budetti, who is still here, what they think the reaction of the pediatric community would be if we eliminated that requirement for direct supervision and made provision for direct reimbursement to institutions where there were preventive health services or health maintenance counseling? That is, in effect, what you are advocating, is it not?

Ms. DURAND. I am advocating—Let me retrench.

Direct physician supervision is required when we are performing medical functions. There is no question about that. Under current systems of care provision, I think that would cover reimbursement for a nurse practitioner who is practicing within organized systems and, hopefully, in collaboration with physicians. I am suggesting that some flexibility be considered for provision of the kinds of services, health maintenance and preventive counseling that are not necessarily authorized by physicians, not necessarily done under their supervision.

Mr. SCHEUER. How would your fraternity react to that?

Dr. BRUYN. First of all, I would like to say that I don't like the term "physician extender" either and for all the reasons that Ms. Durand has said.

Second, I think that pediatricians, certainly through the academy, have made a commitment to the collaborative effort with nurse practitioners. I don't think the reaction would be a significant one. I think there would be a vociferous minority, which we have dealt with for some years, who have written amazing letters to journals describing things in really emotional terms, that I do not share. I think the key is the word "supervision," and that is a very tricky word. I have recently put together a formal presentation which will be published this month, I am told, on the medical-legal aspects of the nurse practitioner. One of the things we focused on in that study was the use of the word "supervision." Does it mean over-the-shoulder supervision? Does it mean at-a-distance supervision? What does that word mean?

Mr. SCHEUER. I have had an opportunity to spend 1 month in Africa examining family planning programs. Most African doctors were educated either in England or in the United States and they tend to supervise their nurses just like they were taught to in medical school, so they have kept in the law that IUD's and condoms and all the family planning devices, pills and so forth, can be prescribed by nurses but only under the supervision of a doctor. It frequently happened that these rural health clinics might be 1,000 miles away from Cenchasa where the doctor is practicing in a very comfortable urban setting, but they have insisted on keeping words pertaining to direct supervision in the language of the law even though the reality is that literally the service is being delivered 1,000 miles away from the nearest doctor. In Africa where you have population ratios of one doctor for anywhere from 25,000 to 50,000 people, they still insist that all health services delivered by nurses must be under the supervision of a doctor, even though health services out of the metropolitan area are almost 100 percent delivered by either nurses or, much more likely, paraprofessionals. Of course, that is the reduction ad absurdum.

Dr. BRUYN. One of the ways in which the word "supervision" can be used, and I think it is a very useful one, is that somebody, the physician, under California law, has a responsibility and therefore he must know the capabilities and the training and the functions of the person that he is supervising. I think one thing we have found, and I think Ms. Durand would agree, is that sometimes nurse practitioners have been used in a setting in which their physician supervisor doesn't even know their name, let alone what their training and capabilities are. I don't think it is necessary to build into a bill such as this a requirement for direct supervision, if that means over the shoulder.

If it means that the physician is available to nurses in the setting that you have just described, the physician knows what capabilities are, he knows what distinct and specific capabilities are and he uses all capabilities in collaboration with him. If that is what is called supervision, that's fine. It is also collaboration. I think the word "supervision" must be qualified in any legislative action so as not to be restrictive.

Mr. SCHEUER. We do not require onsite supervision. Is that OK by you?

Dr. BRUYN. Sure.

Ms. DURAND. I wonder if I could read into the record a comment on the concept of supervision that was made by Ingeborg Mauksch. Ingeborg Mauksch is on the joint practice commission and is currently

senior program consultant in the Robert Wood Johnson nurse faculty fellowships program and a wonderful spokesman for the nurse practitioner movement. What she said was:

> The concept of unilateral supervision is contradictory to the spirit of joint practice. There must be mutual trust based on knowledge of each other's competence in order to engage in joint practice, therefore it follows that mutual advising, monitoring, and/or consulting on request are more desirable descriptions of this process than is the term "supervision."

The National Joint Practice Commission is a body made up of physicians from the American Medical Association and an equal number of nurses from the American Nurses' Association who have been working for the past 4 or 5 years to develop and encourage joint practice between nurses and physicians. I think that concept speaks more to how I would like to see supervision defined than the more narrow concept.

Dr. BUDETTI. Since you asked my opinion, I certainly agree with everything that has been said. One of the reasons I had to leave early yesterday was to get to a clinic which I share with a nurse practitioner. I can assure you that the phrase "physician extender" has been out of my vocabulary for some time. I fact, I think the only consultation that took place last night was that I asked her a question. In fact, I can even come up with some ideas about areas where some physicians should do things with a level of "supervision" by a nurse practitioner.

Mr. SCHEUER. I am sure the profession would welcome that dissertation.

Dr. BUDETTI. On the other hand, I am sure you are well aware that the official position of the academy is quite to the contrary, as reflected in Dr. Robinson's testimony, calling for no direct reimbursement. I personally don't recommend anything that would set up a separate competitive system. I think the idea of collaborative practice is really the basic idea. There are alternative systems already, such as chiropractic, in place. There are lots of other systems in place. I think that what we need is to keep expanding the notion of collaborative practice and appropriate delivery of modern health care and medical care systems. If there is some degree of individual compensation, I certainly would support that, but as you know, that is not anything like an official position of any organized medical body that I know of.

Ms. DURAND. Peter, I agree entirely with what you said, but I think the time is today to ask this question. If a nurse practitioner or a nurse who has a background in education wanted to offer classes to parents for all the reasons that we are saying are good reasons, would she have to be employed by a physician in order to be——

Mr. SCHEUER. Or an institution.

Ms. DURAND. Or an institution to be reimbursed for that service?

Dr. BUDETTI. In my opinion, absolutely not. I fully agree with you that that would be a fully appropriate kind of thing for an independent practice situation. I am just talking about anything that might raise diagnostic or therapeutic liability of any kind, liability to the patient. I think such patient care should be done in some sort of organized system. I am thinking about the Alternative Birth Center in Berkeley,

which really is a step in that direction toward expanding away from a purely medical model but trying to keep a medical component available in an appropriate relationship to the other parts of its existence.

Ms. DURAND. We are in total agreement there. I would like to end my remarks by saying that I am able to be here today and to delay returning to work because my physician colleague is covering for me.

Mr. SCHEUER. Do you think he is fully capable of doing that?

Ms. DURAND. She is.

Thank you for your attention.

Mr. SCHEUER. Thank you very much, Ms. Durand.

[Ms. Durand's prepared statement and attachment follows:]

STATEMENT OF BARBARA DURAND, R.N., M.S., P.N.P., ASSOCIATE CLINICAL PROFESSOR OF NURSING AND CODIRECTOR, PEDIATRIC NURSE PRACTIONER PROGRAM, UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

MR CHAIRMAN AND MEMBERS:

My name is Barbara Durand. I am Associate Clinical Professor of Nursing at the University of California, San Francisco, where I have taught in the Pediatric Nurse Practitioner Program for the past 7 years. I am currently Co-Director of that program, which is operated jointly by the School of Nursing and the School of Medicine. In addition to teaching, I am engaged part-time as a nurse practitioner providing primary health care services to a group of families with young children.

My testimony will address the role of the nurse practitioner in primary child health care in order to assist the committee in its formulation of cohesive manpower policies for primary care, and in its consideration of reimbursement policies for qualified providers of such services.

The development of the nurse practitioner role has been of major significance in providing the appropriate utilization of professional nursing skills in the delivery of child health care. The preparation of nurse practitioners build on previous nursing knowledge and enables them to assume responsible roles in the provision of direct patient care services. Nurses are now managing children and families rather than the system, the environment, and the equipment.

A full description of the functions and responsibilities of the Pediatric Nurse Practitioner was published in 1971 in a joint statement of the American Nurses' Association and the American Academy of Pediatrics. Of particular note in that statement is a paragraph addressing the overlapping of nursing and medical functions, and the issue of the independent role of the nurse.

> "The expansion of the nurse's responsibilities would encompass some of the areas that have traditionally been performed by physicians. Proficiency and competence in performing these new technical skills associated with the expanded responsibility should be viewed as increasing the sources from which the nurse gathers data for making a nursing assessment as a basis for diagnosis and action and thus contribute directly to comprehensive nursing. Nurses must therefore be prepared to accept responsibility and accountability for the performance of these acts and must have the opportunity to be engaged in independent as well as cooperative decision making."1

Inherent in this statement is recognition of the nurse as an independent practitioner of nursing in the delivery of comprehensive health care. And nursing, in California and many other states, has been re-defined legally "to recognize overlapping functions between physicians and nurses and to permit additional sharing of functions ... which provide for collaboration between physicians and nurses."[2]

My own philosophy, that of our program, and that of most nurse practitioners I know, is that primary health care is a cooperative enterprise. Nurse practitioners are not physicians and must consult with, refer to, and collaborate with physicians when medical problems arise. At the same time, nurses are professionally qualified and legally sanctioned to provide a range of primary care services, many of which are described in H.R. 1702, specifically, preventive children's health services, including health assessment, health screening, immunizations, and health education.

I emphasize this point in reference to H.R. 1702 for two reasons. First, in Title II, Part A, Section 201, Subsection 2, the term "physician extender" includes nurse practitioners. Nurses are not new health workers. Nursing is an established profession, and since nurse practitioners provide primary care services under the legal and professional scope of nursing practice, they are not physician extenders. Recent federal legislation dealing with rural health services specified nurse practitioners separately for these reasons.

The other point relates to reimbursement policies. I would hope that distinctions between health care and medical care would be recognized and that options would be provided for utilization of health care services that are not necessarily dependent on the physican. To require direct physician supervision, physician's orders, or physician certification that a service is necessary, when that service falls within the legal and professional purview of the nurse practitioner would be restrictive and, I believe, would inhibit the collaborative physician-nurse practitioner model for providing primary care.

Nurses are aware that the task of re-defining health care for purposes of national health insurance is a difficult one. We applaud the features of this bill that recognize preventive services as legitimate. And we ask for your consideration and support of mechanisms which will reduce the barriers and permit the full utilization of qualified nurses in the collaborative provision of primary health care for mothers and children.

Thank you for your attention.

References:

1. ANA-AAP. "Guidelines on Short Term Continuing Education Programs for Pediatric Nurse Associates," American Journal of Nursing 71:509-512, March, 1971.

2. California Nursing Practice Act, Chapter 6, Article 2, Section 2725.

CALIFORNIA NURSES' ASSOCIATION
Government Relations Office

Language showing combined effect of AB 3124 and AB 2879. Effective January 1, 1975.

An act to amend Sections 2725 and 2726 of the Business and Professions Code, relating to nurses.

LEGISLATIVE COUNSEL'S DIGEST

Redefines the practice of nursing and includes in such definition the planning and performance, according to standardized procedures, as defined, of various services related to direct and indirect patient care and acts of basic health care, testing, and prevention procedures.

Makes legislative declaration and intent.

Authorizes the Board of Medical Examiners and the Board of Nursing Education and Nurse Registration to jointly promulgate guidelines for specified standardized procedures, which if promulgated are required to be administered by the Board of Nursing Education and Nurse Registration.

Revises provision of Nursing Practice Act which provides that the act does not confer any authority to practice medicine or surgery or to undertake other specified acts in violation of any provision of law.

The people of the State of California do enact as follows:

SECTION 1. Section 2725 of the Business and Professions Code is amended to read:

2725. In amending this section at the 1973–74 session, the Legislature recognizes that nursing is a dynamic field, the practice of which is continually evolving to include more sophisticated patient care activities. It is the intent of the Legislature in amending this section at the 1973–74 session to provide clear legal authority for functions and procedures which have common acceptance and usage. It is the legislative intent also to recognize the existence of overlapping functions between physicians and registered nurses and to permit additional sharing of functions within organized health care systems which provide for collaboration between physicians and registered nurses. Such organized health care systems include, but are not limited to, health facilities licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code, clinics, home health agencies, physicians' offices, and public or community health services.

The practice of nursing within the meaning of this chapter means those functions helping people cope with difficulties in daily living which are associated with their actual or potential health or illness problems or the treatment thereof which require a substantial amount of scientific knowledge or technical skill, and includes all of

the following:

(a) Direct and indirect patient care services that insure the safety, comfort, personal hygiene, and protection of patients; and the performance of disease prevention and restorative measures.

(b) Direct and indirect patient care services, including, but not limited to, the administration of medications and therapeutic agents, necessary to implement a treatment, disease prevention, or rehabilitative regimen prescribed by a physician, dentist, or podiatrist.

(c) The performance, according to standardized procedures, of basic health care, testing, and prevention procedures, including, but not limited to, skin tests, immunization techniques, and the withdrawal of human blood from veins and arteries.

(d) Observation of signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition, and (1) determination of whether such signs, symptoms, reactions, behavior, or general appearance exhibit abnormal characteristics; and (2) implementation, based on observed abnormalities, of appropriate reporting, or referral, or standardized procedures, or changes in treatment regimen in accordance with standardized procedures, or the initiation of emergency procedures.

"Standardized procedures", as used in this section, means either of the following:

(1) Policies and protocols developed by a health facility licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code through collaboration among administrators and health professionals including physicians and nurses;

(2) Policies and protocols developed through collaboration among administrators and health professionals, including physicians and nurses, by an organized health care system which is not a health facility licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code. Such policies and protocols shall be subject to any guidelines for standardized procedures which the Board of Medical Examiners and the Board of Nursing Education and Nurse Registration may jointly promulgate; and if promulgated shall be administered by the Board of Nursing Education and Nurse Registration.

Nothing in this section shall be construed to require approval of standardized procedures by the Board of Medical Examiners or the Board of Nursing Education and Nurse Registration.

SEC. 2. Section 2726 of the Business and Professions Code is amended to read:

2726. Except as otherwise provided herein, this chapter confers no authority to practice medicine or surgery.

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Mr. SCHEUER. And now, Virginia Fowkes, director of the primary care associate program, Stanford University.

Is that the medical school or the nursing school?

STATEMENT OF VIRGINIA FOWKES

Ms. FOWKES. That is the medical school.

Chairman Scheuer, I am very happy to be here. As you mentioned, I am director of the Stanford primary care associate program, which is an approved physician's assistant program in the State of California. My professional orientation and commitments——

Mr. SCHEUER. Would you rather be called a physician assistant than a physician extender?

Ms. FOWKES. I'm a nurse practitioner.

Mr. SCHEUER. In other words, you like "nurse practitioner" and you don't want the "physician extender" label? You want to stick to that and you don't want to be called a "physician" hyphen anything?

Ms. FOWKES. No, I don't. My professional orientation and commitments involve the preparation of family oriented health care professionals. For this perspective, I would like to say that I am a proponent of national health insurance for everyone, and worry about the inherently object to sequestering one segment of our population for such services.

However, I certainly have been impressed with what I have heard from you and other people and what I have seen in the bill. As I understand the nature and intent of this legislation, it is a politically realistic stepping stone to a comprehensive national health insurance program for all. I am concerned about the additional administrative costs associated with setting up very special services for a segment of the population.

I questioned why I was asked to comment at these hearings and assumed that this related to my role as an educator of physician's assistants and nurse practioners, and accordingly will confine the remainder of my remarks to that purview.

I am very glad to see that "physician extenders" are included in the bill. I don't like the terminology either, for the very same reasons that Barbara Durand so eloquently described.

Mr. SCHEUER. You can rest assured that the phrase has been exorcised from my vocabulary, and it will shortly be exorcised from the draft of bill.

Ms. FOWKES. When I refer to this category of pratitioners, I speak of nurse practitioners and physicians' assistants and nurse midwives. These individuals certainly play a major role in the assessment and care of mothers and children. Indeed, they are an important source of health manpower which may become critical when there are increased demands for services. I certainly hope that a physician's assistant and nurse practitioner will be included in the proposed advisory council and other aspects of program administration.

With you permission, I would like to digress from my written statement and cover some questions that have been raised in the process of testimony. I heard the morning sessions yesterday and at that time was asked to speak to the issue of reimbursement. My position on reimbursement for physician's assistants and nurse practitioners is

basically that contained in Dr. Lee's testimony yesterday, which referred to reimbursing key practices rather than independent practitioners. I believe in the concept of a team practice or a system of providing services. I do not feel that nurse practitioners or PA's should practice independently. For that matter, most physicians do not practice independently and are certainly dependent on one another for support, sharing calls, referral, and so on. I believe that all prividers today should practice interdependently. As I interpret the language of the bill, it appears that nonphysician practitioners can be reimbursed directly for services. While I feel that this is a giant step forward in recognizing the potential of these providers, I believe that indirect reimbursement through the physician provider number is the only way at the present time to assure adequate consultation and supervision.

Mr. SCHEUER. Supervision by whom?

Ms. FOWKES. By physicians.

Mr. SCHEUER. Do you think we should require supervision by physicians?

Mr. FOWKES. I listened to what was said about supervision, and the important thing, to me, is that there is some system for collaboration. Dr. Budetti expressed my philosophy in this area very well, I assume that you know that physicians' assistants do practice under the direct supervision of physicians as required by State law. However, an interesting tangent on that idea, is two physicians in the State of California who are hiring physicians to supervise their practices. These individuals have located in rural remote areas where physicians are not practicing, and are supervised through telephone communication or some electronic means.

Mr. SCHEUER. Now, who are these people who hired physicians?

Ms. FOWKES. Two physicians' assistants.

Mr. SCHEUER. And they practice under a physician's supervision by telephone?

Ms. FOWKES. Yes.

Mr. SCHEUER. What are these electronic devices you are talking about, open circuit television, anything that sophisticated?

Ms. FOWKES. No, nothing that expensive or that sophisticated. What it amounts to is a direct telephone line to the physician's office. The practice, basically, runs no differently than most other practices. The physician assistant or nurse practitioner can handle 75 percent of patient problems within the practice and refer to the remainder appropriately.

Mr. SCHEUER. Well, many millions of Americans got what for most of them was the best health care they ever had in their lives during World War II, and 90 percent of it was delivered by other than professionals. On the battlefield, 100 percent of it was delivered by other than professionals, blood transfusions, administration of drugs, tracheotomies, and some other minor operations. I don't think there is any doubt that the overwhelming preponderance of day-to-day health care can be delivered very well by other than professionals.

Ms. FOWKES. There has been a lot of discussion regarding rate of reimbursement and I just wanted to make the point that certainly the rate of reimbursement for PA's and NP's should be 100 percent or the same as for physician's services. Our health care system is set up on a fee-for-service basis, and I feel that if the quality of the service is the same, the cost should be equivalent, no matter who renders the service. I think we have established and proven the fact that a physician

assistant or nurse practitioner can perform a complete physical examination as well or better as the physician.

Mr. SCHEUER. Why do you say "or better"?

Ms. FOWKES. Well, for one thing, we have established and set up our practices so that PA's and nurse practitioners spend more time with patients than physicians do, and inherent in performing a good physicial examination is time.

Mr. SCHEUER. And more time for communication with parents and with patients?

Ms. FOWKES. And more time for communication with patients.

Mr. SCHEUER. And perhaps even more skill in communicating with patients, because that is really what you do most of your time.

Ms. FOWKES. Yes. I also wanted to address a couple of questions that you raised yesterday. One of these concerned lack of support for health legislation. For most people, I think health is a low priority item, until they get sick or have a need for services and can't obtain them. If we ask poor people what they want from the Government they're going to list food, clothing, shelter, and health care is going to be rather low on the list. Unfortunately, it is, by and large, only the providers, educators, and people who have been directly affected who realize these needs and consider health care a high priority. You also asked about health education. I am very excited about your views and interest in this area. Although the comment was made earlier today that pediatricians are perhaps more skilled and/or more interested in this area than other physicians, I still question this in that when I took my children to the pediatrician for either health maintenance or care of illness, I don't ever recall one instance where the pediatrician spent more than 5 minutes in time with me or my child.

Basically, in this country we train physicians to treat or take care of disease, not health, and we cannot turn around and expect them to do something that they weren't trained to do, that being health education. I think we need to change our system of medical education or perhaps, more realistically, rely on some other systems to address this. I see PA's and nurse practitioners as having major responsibilities in this area, and also the school systems, which was brought out very well yesterday. You might say that, just as war is too important to leave to the generals, health care is too important to leave solely to physicians.

I have other statements in my written testimony, but I think I will stop here unless you have specific questions.

Ms. NELSON. Who gets paid when a physician's assistant sets himself up independently in a rural area under a physician's supervision? Does the physician get paid for their services?

Ms. FOWKES. Yes.

Mr. SCHEUER. Well, you said that they hired the physician.

Ms. FOWKES. Well, now, if you are talking about reimbursement, I am not exactly sure how the practice works but it would have to be through the physician.

Mr. SCHEUER. But I thought that the nurse practitioners or the PA's hired the physician to supervise them so that they could work?

Ms. FOWKES. This is just two instances that I am talking about where this happened. I would doubt in that situation that they are taking care of medicaid patients. If they are, it would certainly have to be billed through the physician.

[Ms. Fowkes' prepared statement follows:]

STATEMENT OF VIRGINIA FOWKES, DIRECTOR, PRIMARY CARE ASSOCIATE PROGRAM, STANFORD UNIVERSITY, CALIFORNIA

I am Virginia Fowkes, Director of the Stanford Primary Care Associate Program, an approved physician's assistant training program in California. My professional orientation and committments involve the preparation of family oriented health care professionals. From this perspective I am a proponent of National Health Insurance for all people and inherently object to sequestering one segment of the population for such services. However as I understand the nature and intent of this bill, it is a politically realistic stepping stone to a comprehensive national health insurance program for all. It certainly could be argued that such a bill might eliminate pressure temporarily and therefore delay a national health plan, but of course that is purely conjecture. I am concerned about the additional administrative costs associated with setting up very special services for a segment of the population.

I questioned why I was asked to comment at these hearings, assumed this related to my role as an educator of physician's assistants and nurse practitioners, and accordingly will confine my remarks to that purview.

I am glad to see that "physician extenders" (though I do not like the terminology) are included in the bill as these individuals play a major role in the assessment and care of mothers and children. Indeed they are an important source of health manpower which may become critical when there are increased demands for services. I do hope that a physician's assistant and nurse practitioner will be included on the proposed advisory council and other aspects of program administration.

Because of the nature of my own program, I am particularly concerned about needs in rural and medically underserved areas. The bill requires specific size limitations for units in which obstetrical or pediatric service must be delivered. The population of many rural towns is small and so are the facilities which may not qualify. In addition, the "grouping of physicians" as suggested in the bill, although feasible in metropolitan areas, would be difficult in rural ones. Accordingly we could disenfranchise the very areas most in need of services and I think this is a big set of questions to leave for regulation. I do think the capitation plan would be an ideal setting for utilization of physician's assistants and nurse practitioners in that these individuals can deliver most of the services needed and are not as expensive as physicians.

I would like to take a moment to acquaint you with what we think are unique efforts in our state to increase the deployment and flexibility of physician's assistants and nurse practitioners. Much of our training is decentralized. Though coordinated by the university health science center, effort is made to recruit students who live or work in health care deficient areas and take the training programs to them by developing community based resources for training. There is a high correlation between where students are trained and where they eventually practice. Currently 87% of our program's graduates are practicing in shortage areas. Using this approach our program at Stanford and the University of California at Davis Family Nurse Practitioner Program are training physician's assistants and nurse practitioners cooperatively throughout the state in the decentralized network. We believe these 2 professionals share more in common than not and are interested in combining resources to provide improved and more cost-effective education. You also may wish to know about the California Council of Nurse Practitioner and Physician's Assistant Programs, an organization of the major programs (17 in number) which have joined together to share educational resources and work cooperatively to effect legislation and other important activities which impact on the utilization of these practitioners.

I mention these considerations because it is obvious to me should this legislation pass, nurse practitioners and physician's assistants would be called upon to deliver these services in remote communities - a fact which should be considered in writing regulations for this legislation.

Thank you.

Mr. SCHEUER. Ms. Jane George.

STATEMENT OF JANE GEORGE

My name is Jane George. I am assistant administrator of ambulatory services at Alta Bates Hospital. I am also a member of the advisory board of the East Bay Child-Birth Resource Center.

I think I had a fairly typical response as a provider who deals at the paperwork level. When I originally read this bill, I had some concerns that by the time it is implemented and the system is set up and the regulations get written, that we will have another medical on our hands. I hope that is not true. Those concerns are in the back of my mind.

I would like to make just a couple of general comments about cost and about its effect on access of choice. I will confine my comments to maternity care. I know more about that than I do about pediatrics. Maternity care has some very major problems relative to insurance. Medicaid patients have a terrible time finding physicians because the reimbursement to physicians is really low. The patients who have private insurance often have poor or no maternity benefits associated with that and they are also usually at a point in their earning life where it is very hard for them to handle a medical bill.

One of the strengths in your bill, frankly, is the fact that it provides for the common benefit for everyone in the community. I wonder, though, if it doesn't pay too much. Because patients have so much difficulty accessing care, because of the money barrier, they, at least in this community, have become very good consumers of health care. They have become educated consumers of health care. I think that I know of no other single group of consumers who have read as much, who have explored their alternatives as much, who have questioned the system and what it does to them as much, and who have insisted on having a choice about the various options as vigorously. I fear losing that, and the reason that I am afraid of losing that is because I firmly believe that it promotes health; that the people who explore the system, who go out to seek to educate themselves, who seek the education that we are talking about in this bill, are healthier people as a result of that.

Mr. SCHEUER. There is a terrific self-selection process in that.

Ms. GEORGE. Oh, sure.

Mr. SCHEUER. And those people, in the absence of any government of any kind, are the kind of people who find out by hook or by crook where the resources are and how to manipulate whatever system there is. By some do-it-yourself device, they manage to be healthier than the rest of the population just because they are so extraordinarily motivated.

Ms. GEORGE. Are they motivated because they are pregnant or are they motivated because they are shopping?

Mr. SCHEUER. Well, they are shopping because they are motivated. They are shopping because they are A, pregnant, and B, motivated. There are an awful lot of pregnant women who don't shop and aren't motivated.

Ms. GEORGE. That's true enough; it's just that I think within that particular group there seem to be more educated consumers than there are in any other element of the population. I think probably the women's movement has had something to do with that, but I

think economics has had something to do with that, too. If we are going to pay 90 percent or 100 percent, is that kind of phenomenon going to continue? I am not sure that it will. I am concerned that you have made your estimate for cost on the basis of current utilization. Are we going to get into the same kind of phenomenon that we have run into with medicaid, and that is, when it is all paid for, patients start to overuse the system without really thinking about it.

Mr. SCHEUER. That is one of the abuses of medicaid, but still and all, if you have the choice between providing a small percentage of the population with services or providing everybody with service and running the risk of some overutilization, which way are you going to go? It is very difficult to fine tune a government program so that you provide these big amorphous population groups with exactly as much as they need and no more and no less.

Human wisdom doesn't enable us to do that. If we have to choose between leaving a lot of people unserved or providing a system and a network and reimbursement provisions that will really hit almost everybody, there are going to be some people who will manipulate the system so that they get more. If you try to set up barriers against overuse of the system, those same barriers are going to cut people off from the system who need to have access. The whole business of copayment is terribly complicated. You take an elderly person over 65, how much do you ask them to pay themselves for pills, for drugs, or visits to the doctor? It will be so finely tuned that it will be just enough to keep them from being silly abusers of the system and using it for social purposes and socialization and so forth, but not enough of a barrier to keep people who really need help and who should get help early on, at the beginning stages of an illness rather than saying, "Well, I'll save the $2 or $5 or 50 cents and maybe this will go away," and then having them come to the system when they are really sick.

Ms. GEORGE. I guess I am concerned about cost containment as a general thing for the system and that there are many people who have responsibilities or who will have to have responsibilities for participating in cost containment. There is going to be provider responsibility and there is going to be patient responsibility and there have to be incentives in both places. I am not sure how you provide that.

Mr. SCHEUER. Somehow or other we have to put into these programs an incentive, not only to the doctors and the institutions, but also to the people involved to be healthy. There ought to be some kind of payoff for health. Now, the hospitals get that payoff for sickness. They get that payoff when they fill all those beds at $300 a day.

Ms. GEORGE. That's right, and as somebody who has been looking at the red bottom lines for ambulatory services which have been poorly reimbursed, I can appreciate that.

Mr. SCHEUER. And the hospital administrators send out letters to their attending physicians regularly saying, "In order to provide the services that this community needs, you've got to keep sending the patients in." They not only send the patients in, but they send them in on Friday, knowing that absolutely nothing is going to happen to them until Monday morning.

Ms. GEORGE. But they can go skiing for the weekend?

Mr. SCHEUER. The doctors can go skiing for the weekend and the hospital knows that they are going to be collecting the $300 bucks a day for Friday, Saturday, and Sunday. It seems to me that the sheer existence of a maternal/child health bill which, in essence, is preventive, which in essence is health oriented rather than sickness oriented and crises care oriented, is in itself an element of cost containment, looking at the whole health care system as a totality.

Ms. GEORGE. I hope you are right.

Mr. SCHEUER. Well, it seems to me that I am right. Now, what you are saying is, let's try to fine tune this program further.

Ms. GEORGE. Part of this fine tuning will come, I hope, from public education and from that element of education that you have built into this bill. Perhaps patients who are educated to use the system more effectively will also use it more efficiently. I certainly hope so.

Mr. SCHEUER. A lot of the problem with the elderly, with medicare, is that elderly people are using the system for socialization. They are lonely, they are alone, they want somebody to talk to, somebody to listen to their problems.

Ms. GEORGE. The waiting room phenomenon, the patients who come to the clinics and have their social hour.

Mr. SCHEUER. Yes, and I don't think you are as likely to have that with mothers of small children because mothers, by the sheer fact that they are mothers, have a social life. They have a young infant dependent upon them, so there is communication, there is company, if they want it.

Ms. GEORGE. Oh, I know some mothers who would disagree with you vehemently.

Mr. SCHEUER. I would think from my superficial knowledge of the subject that there would be less need for socializing on the part of mothers than, apparently, elderly people feel. I could be wrong.

Ms. GEORGE. One of the great problems, I think with parenting, and one of the things that leads to some of the problems that we have, for example, with child abuse, is the fact that a young woman who has been fairly free to come and go now has this child that she has to deal with and she can't run across the street to Susie Smith's and have her morning cup of coffee or she can't go shopping with Sally Jones in the afternoon because there is this child there. There are times when that child becomes something that interferes, unless she has done a very successful job of adjusting to that child. Not all people do successful jobs of adjusting, so I question whether the difference is very great between the maternity patient and the elderly patient.

Mr. SCHEUER. I think that most of my observations have been the subject of general disagreement by our audience. I stand corrected.

Ms. GEORGE. I think it was Dr. Breslow that made some comments, perhaps it was Dr. Bruyn, I can't remember for sure, about rates and reimbursement and the fact that those have to be at some kind of realistic level. That is true for physicians. I think it is true for institutions, too.

We have some economies that are possible with centralization. I think we have shown that, but even with large and very high utilized obstetrical services, we have never picked up in charges what the costs of operating those services are, for the very reason that those patients have been least insured, least able to handle the cost of

maternity care. I am afraid that as we begin to get large institutions that have to respond to some kind of prospective reimbursement scheme that perhaps is based on some sort of base year, which in itself is perhaps not very realistic relative to cost, that we will get into a baby factory situation, that some of the individuality that consumer groups have insisted upon in obstetrical services will go by the wayside. There will be one large center rather than several small ones. The patients will no longer have a choice. They won't be able to shop, and they perhaps will get into a kind of routinized, mechanized baby factory. We already have some of that now and I would hate to see it go any farther. If anything, may be we need to go back the other way, but whenever we deal with individualized maternity services, we also deal with a very high expense. The expense in maternity services is really very small for technology and very high for manpower. It is the manpower that would have to be effectively reduced to effectively reduce costs or retain co[illegible]en they just line the patients up with the fetal monitors and [illegible] nurse sits at the desk looking at the pictures and one nurse goes around with a glove and examines the patient, that is the kind of thing we don't need.

I consulted some consumers and a childbirth educator before I came. I had them look at the bill with me, and they both focused on health education. They had some of the same concerns that I do, but their comment was pretty much that the bill seems to provide some education for patients. Can you recognize that consumers, at least the motivated consumers we were talking about a little while ago, believe that providers need some education as well? I think their point is that providers—we tend to be rather single-minded about who knows best what patients need. Our pregnant patients right now, at least, believe that maybe we don't know as well as we should, that we are not sharing our information with them, we are not really giving them a clear picture of what their options are, and that we make a lot of rules and unless we can justify these rules, rationalize these rules, we ought to get rid of them. Patients are really asking us to go one step beyond telling them what the risks are. They want to know what their options are as well. Mara Halprin, one of the ladies that I talked with, said, "Why doesn't he write 'provides education' to that statement."

Mr. SCHEUER. Tell us something about this alternative birthing center.

Ms. GEORGE. I guess I am the resident expert on alternative birthing. We began to get some requests from patients and from some of our physicians to recognize the normalness of childbirth and to recognize that there are many pregnancies which are perfectly normal, very low risk, and not in need of much technology that we have superimposed on medical care in obstetrics.

Mt. Zion is the first in the area that I am aware of that started an alternative birth center. We have one now; we have about 8 months of experience with it. What we did was take a room and decorate it like a home bedroom and as much as possible preserve the atmosphere of a home delivery in the hospital. Our alternative birth center is about 150 feet away from the regular labor and delivery rooms, so if there are any major complications we can transfer the patient very quickly to the technology if they need it, but other than that, we have

avoided things like stirrups and sterile drapes and some of the trappings that you see in a delivery room and have let patients pretty much have their way in collaboration with the doctor and the nurse in the delivery of the baby.

Mr. SCHEUER. In what regard do they have their way?

Ms. GEORGE. Laboring position, delivery position, episiotomy, no episiotomy.

Mr. SCHEUER. What does that mean?

Ms. GEORGE. It is an incision that is made to ease the birth of the child and a subject of great controversy in obstetrics right now. The atmosphere is not very restricted. Patients are much freer to move around, to do whatever is comfortable for them. They are just more comfortable in their room. There is kind of a sense of safety that doesn't exist in regular labor and delivery because of its rather sterile appearance. We have kind of put the control back in mother's hands. In reality, she is the one who is delivering the baby, not the doctor, although sometimes that phrase gets turned around.

Ms. DURAND. Do the options include who is present at the birth?

Ms. GEORGE. Yes. Anyone can be present. We have had children present at the birth, friends, they can take all the pictures they want to. We had one woman in the birth center who had eight children at home and she wanted them all to see the baby at some point very early in the baby's life, so the older children were there to participate in the baby's birth and the younger children came in later to see the baby and it was really a family affair and very exciting for them. I think the younger children did not suffer from mother leaving them for 3 days. She did not come home with this "thing" and therefore this "thing" must be responsible for her being gone for 3 days. It is an alternative; it is different. Not everyone needs it and not everyone wants it. As you might guess, not everyone in the medical and nursing community has accepted it particularly well.

Mr. SCHEUER. Now, do Peter Budetti and Dr. Bruyn have any questions?

Dr. BUDETTI. What about the costs of the alternative birth center?

Ms. GEORGE. I think we have probably eliminated a little bit of the technology cost, which as I said, is not tremendously great. The manpower is perhaps a little less because we staff it out of labor and delivery and therefore there is no downtime involved. It depends on how you do your calculation. I don't think it is tremendously less expensive, a little bit perhaps.

The other thing that we have built into that program is an early discharge. Those patients are very carefully screened for normal pregnancies and after delivery. Those patients can go home within 12 hours after delivery and we provide nursing visits for them at home, so for the price of a $40 nursing visit at home, the patient saves a day of hospitalization, which in this community is running around $260 a day for the mother and the nursery.

Ms. FOWKES. Can the patients in the birthing center have anesthesia?

Ms. GEORGE. No. They are all natural childbirths and we insist that they all be prepared for natural childbirth through some kind of formal training. We don't specify what method but some kind of preparation. We get nice pink babies because there isn't any anesthesia.

Mr. SCHEUER. And the anesthesia makes them look bluish?

Ms. GEORGE. Some patients who are heavily medicated, and perhaps the doctors can speak to this better than I can, tend to have lower APGAR scores. It is a set of criteria that is used to rate a baby at the time of birth, based on the color of the baby's skin and its reflexes and things like that.

Mr. SCHEUER. Thank you very much. It has been very informative and we are grateful to you.

[Ms. George's prepared statement follows:]

STATEMENT OF JANE GEORGE, ASSISTANT ADMINISTRATOR, ALTA BATES HOSPITAL, BERKELEY, CALIF., AND MEMBER OF ADVISORY BOARD, EAST BAY CHILD-BIRTH RESOURCE CENTER

Ladies and Gentlemen:

I must admit that I read HR-1702 with dismay initially and for reasons this committee has no doubt heard repeatedly: another increment in an already complex and fragmented health care system that deals with health care only and does not tie in other and perhaps more significant needs pregnant women and children; another costly system of boards and councils and rate schedules and cost reports and audits and approvals, etc., ad nauseum; another tax and one where the tax payer may again see himself as not reaping any personal benefits; another intermediary; another set of doors for patients to walk through in seeking support for care, and a preponderance of language dealing with organization, operation, qualification, and financing of the system as opposed to many fewer words addressing patient need, access, and choice.

The proposed modifications to the bill make it somewhat more palatable, and subsequent readings reveal that there are potentials for using existing systems for implementation rather than creating completely new ones. But still the concern remains for patients and for what this bill will do toward

improving even a portion of this nation's health. Most of the bill is deserving of some review. But in the interest of limited time I have chosen to comment on the general area of cost and its effect on access and choice and to stress the area of maternal care since I am most familiar with that.

There is no question that insurance benefits - particularly for maternity care - are poor. Patients with Medicaid have difficulty finding physicians as the reimbursement to those providers is low. Other patients with private medical insurance have limited or no maternity benefits and pregnancy often occurs at a time in earning-life when patients can ill afford a large medical bill. Herein lies one of the bills strengths in providing common benefits for the entire pregnant population and has the potential, at least, for avoiding double standards of care.

I wonder however, if it pays too much. Because of the difficulty in accessing care due to the money barrier and because many patients pay a significant amount out of pocket, the pregnant have, in urban areas at least, become excellent, educated consumers of health care. I know of no other single group of health care consumers who have read as much, explored alternatives as thoroughly, questioned the system as extensively demanded a choice of options as vigorously, or used the system so wisely. This group has taken a great deal of responsibility for its health, has actively participated. I fear loosing that because I firmly believe that it promotes health. I fear overuse of the system and therefore spiraling cost as a result of blanket payment.

This is not to say that those with very little resources should not receive maximum help and the bill does identify populations with greater needs. But how does one go about preserving the benefits of patients responsibility.

Interestingly, but not surprisingly, proposed payments to providers are based on prevailing rates in a base year rather than cost. I cannot believe that the staff who developed the language in this bill is unaware that hospitals for years have absorbed elsewhere a significant portion of cost associated with obstetrical care for the very reason that this group of patients has been least prepared to handle the cost of care. Contrary to popular belief, this is not limited to under utilized facilities - only exaggerated in them. I would suggest a look at the California Health Facility Commission Cost Reports as one source for evidence of this.

You see the problem certainly. The provider is reimbursed at inflated base year rates which do not cover costs. Those costs are absorbed and therefore paid for by other patients - patients who are paying for their own health insurance because they do not have National Health Insurance, and are also paying a portion of the taxes which support National Health Insurance for maternal and infant care.

Or, perhaps we have need to reduce the cost of obstetrical services. There may be some economies of scale with centralization and high utilization of OB services. But, as I indicated above, even in large and highly utilized services, costs exceed charges and have for a number of year. While technology does contribute some expense to obstetrics, the greatest expense is in man-power and patients get, need, and expect a great deal of one-to-one attention.

We are left then with reducing services to patients in what is admittedly a highly individualized service. I fear greatly routinized, automated, and admittedly less expensive baby factory approaches to maternity services where patients will lose the choices and options and flexibility that this consumer group has fought for so hard.

I have addressed above some concerns regarding the change in current patient behavior with a blanket payment system and therefore a much greater potential program cost that has been estimated. We have seen that happen before and all of us have at one time or another seriously questioned the benefits of such extensive use of health care resources.

I have also questioned the necessity for and the cost of yet another administration for another segment of health needs. Yet, it appears that at least part of the proposal replaces something that already exists, has the potential for using the existing Medicare network for reporting and reimbursement and perhaps the local PSRO's for rate setting boards. There will doubtless be considerable administrative cost both national and intrainstitutional associated with this program, but I think I recognize the hand that has attempted to minimize that and I offer my congratulations. It appears that someone is trying to simplify the organizational chart - or at least prevent it from becoming more complex than it is.

One final comment: Even the best and most comprehensive National Health Insurance plan will not, in isolation, go very far towards maintaining this nations health, nor will the best health care cost containment program, in isolation, significantly reduce the cost of improving that health. We

need to simplify that organizational chart even further and find mechanisms for tieing health care to other programs addressing problems with housing, sanitation, maintenance of nutrition and multitude of other needs which are the major contributors - or detractors as the case may be - to health. Our clients - ourselves - have too many doors to walk through - too many agencies to visit- to many applications to fill out - too many cards to carry - too far to go with the complexities that we have created in the attempt to help ourselves. These problems exist for all of us to some degree and are tremendously exaggerated for the poor and especially the rural poor. I would like to see my health bill address the need for coordination at some level of federal programs affecting health, recognizing of course, that that task is a night mare.

The consumer deserves to have the last word. I consulted a consumer and a child-birth educator and asked them to review this bill with me. They have expressed some of the same concerns that I have expressed to you but both of them focused on the education element in section 216. Is health education to be limited to the patients knowledge of pregnancy, nutrution, and perhaps even be extended to one of the methods of child-birth preparation. Or, will the Congress recognize that consumers believe the providers of care need education as well. Their point is that as fine a health system as we may have, the providers of health care tend to be somewhat single minded when it comes to determining who knows best what patients need. Certainly we providers believe that we have a great deal of skill and knowledge and data but patients are asking us to share that knowledge with them, to outline for them what their options are - not just their risks, their options - to explore some patient initiated alternatives, and to offer rational explanations for our rules or get rid of them. Perhaps this bill should be modified to include education for us as well.

Mr. SCHEUER. We will now hear from Samuel J. Wycoff, professor and chairman of the department of preventive dentistry and community health at the University of California.

STATEMENTS OF SAMUEL J. WYCOFF, DMD, PROFESSOR AND CHAIRMAN OF THE DEPARTMENT OF GENERAL DENTISTRY, UNIVERSITY OF CALIFORNIA, SAN FRANCISCO; AND CAROL SPAIN, ADMINISTRATIVE DENTAL HYGIENIST, DENTAL HEALTH BUREAU, ALAMEDA COUNTY HEALTH CARE SERVICE AGENCY, OAKLAND, CALIF.

Dr. WYCOFF. I am Dr. Samuel J. Wycoff from the University of California in San Francisco. I am chairman of the department of general dentistry, which is a component of the dental school that includes preventive dentistry and community health. It has recently been changed from the title preventive dentistry to general dentistry. I do have a brief formal statement that I would like to make and then Ms. Spain would like to make a statement. We would then be glad to answer any questions you have.

Mr. SCHEUER. As I said before, both of your prepared written statements will be printed in the record, so you can just talk.

Dr. WYCOFF. I think, then, that I will omit the preamble to my comments about the needs for dental care and what the dental conditions in this country are and perhaps zero in on a great concern of mine, and that is that dental care is so often overlooked and is not included in many of the health programs that we see both nationally and locally. I think that sometimes that the more emotional health issues take precedence over dental care and that some of the more popular health programs and ideas are included. It is extremely gratifying to me that this proposed act has a particular provision for dental care and for preventive dentistry. Of course, my principal interest is in preventive dentistry.

I do have a couple of comments on the proposed regulation which I feel might strengthen it. I feel that to overcome the oftentimes overlooked field of dentistry that in the administration of the program that there should be an identifiable person with dental expertise to ride herd on it, so to speak.

Mr. SCHEUER. Ride herd on the dental aspect?

Dr. WYCOFF. Yes; I think many times the dental aspect, although I am very gratified that it is a proponent of a general approach, I do think that many times the dental component is supervised by people who don't have dental expertise.

Second, I think a built-in incentive—I am very gratified about the professional services, but my next comments have to do with the community and with the school activities. I think a built-in incentive such as a grant in aid program for fluoridation equipment, for example, would be something that would strengthen the preventive components. I think this would be a great incentive to get communities to flouridate that have not already, because their principal complaint many times is that they cannot afford the equipment. The equipment is relatively inexpensive and I think it would be a great investment for the preventive aspects because I do feel that fluoridation is the most effective preventive measure we have in dentistry and in health, for that matter.

A third comment that I have is that I think there should be some reimbursement to schools on a capitation basis for instituting preventive programs such as fluoride mouth rinses, deplaquing programs, health education programs, nutritional counseling. I think the time has come when we cannot ask schoolteachers to carry out our health programs and I think there are going to have to be some trained people who are paid to provide these kinds of services. I think we have experienced a great deal of very good programs here in the bay area and other parts of the country with the programs in the school systems, but I think we are going to come to the end of the line when we find schoolteachers who are willing to spend some time doing some of the health activities that should be done by someone who is paid. I think that a capitation program for which the schools would be reimbursed would be a significant asset to the proposed legislation.

I think a waiver of the copayment provision for the children who participate in these school programs would be something that I would find highly desirable. If the children who are in the schools did participate, were actively involved in these preventive programs, then I think the copayment should be waived in those cases. I think that would be an incentive for the children to participate more actively in the preventive program.

I spoke previously about incentives for health. In our opinion, we have to have them. We found in a program in Oakland, for example, that if we gave the children a trip to Disneyland every once in a while, they were more active in the preventive dentistry program we had there.

Mr. SCHEUER. How do you quantify health? What does a child have to do to show that he is healthy?

Dr. WYCOFF. Well, it is very easily quantified in dentistry, of course. You know you can give a child health education information and test them and they get 100 on the health test, but if they have a mouth riddled with decay or gingivitis, then I don't think we quantified health very well in that regard. In dentistry it is very easy to quantify it. You can look and count it. It is not so easy in the other health areas, as I am sure you are aware.

I do feel another aspect that I would highly recommend is that there be payment for emergency dental service for children under the age of 3. I am very gratified to see in the revision that the age has been reduced to 3 for children in the dental aspects.

Mr. SCHEUER. Is that age adequate?

Dr. WYCOFF. Not adequate absolutely, but I think it is a realistic age. The deciduous teeth are erupted about age 2 and by age 3 they would be very prone to decay because they had been at risk for 1 year, so I think 4 would be absolutely too late. Three is much better; 2 would be more ideal. In regard to age, I would certainly not see it reduced in age too. I think that would be a grave mistake, as evidenced by the New Zealand program where, if you cut the age down too low, then you still have children in the high caries prone age and their habits have not been absolutely developed to prepare for taking care of themselves.

Mr. SCHEUER. What was the cutoff in New Zealand?

Dr. WYCOFF. It used to be 16 or 17 when they got out of school. Now it is 19 where the care is provided by the dentists rather than the New Zealand nurses. I don't know if you knew about the New Zealand

nurse program, but it is for children in the schools. When they left school, they were still in the high caries prone age and they developed new caries after they got out of school and there was no nurse to take care of them. Now, they have extended it to 19. A study in Massachusetts showed that children who were in a program very much like this that if they left the program too early they reverted back to the conditions they were in before they were treated. There were no preventive aspects.

I think payment for emergency dental service to the children under the age of 3 would be highly desirable.

Mr. SCHEUER. Under the age of 3?

Dr. WYCOFF. Under the age of 3 for emergency dental service.

Mr. SCHEUER. Would you care to give us some language that would cover it?

Dr. WYCOFF. Well, for such things as traumatic fractures of the teeth, when they might fall, these sorts of things. Children many times are involved in accidents when they are quite young. The front teeth are especially prone to this kind of injury. That would be the main one that I could think of, a traumatic injury to the mouth. I have treated children myself who are age 18 months who I have to treat under a general anesthetic because of injuries due to falls and other injuries.

I think reimbursements for dentists who participate in the repair of congenital deformities in these programs for children under age 3 would enhance this very important reconstructive program. Dentists, especially oral surgeons and orthodontists are many times, for example, involved in cleft lip and cleft palate teams, and they are repaired much earlier than age 3. If there were no dental reimbursement for this, there would be no incentive for the dental component. This would be a great loss to the teams. Of course, I don't think the dentists would withdraw from treating, but I do think there should be that reimbursement for dental services for these types of congenital defect reconstruction programs.

Mr. SCHEUER. What happens now?

Dr. WYCOFF. During the reconstruction programs? Usually, the cleft and the lip are operated on quite early.

Mr. SCHEUER. But you say there is no reimbursement?

Dr. WYCOFF. There is now if it is in a private program, but according to the legislation as I understand it, there would be no dental reimbursement under age 3 and many times these reconstruction programs begin under age 3. I am saying that in these team approaches, I feel that there should be a reimbursement for the dental services under age 3. Many times obdurators, which are replacements for the cleft palate, need to be made and there needs to be an orthodontic intervention quite early. I do feel that this would be very important.

I might end my informal testimony by telling you that I feel this legislation, if enacted, would go a long way toward alleviating many of the general health problems experienced by pregnant women and children, and would be a decided step forward in preventing and treating the many dental ills which I have cited. I would like to express my support for this bill. When Carol is through with her testimony, we would both be glad to answer any questions.

Mr. SCHEUER. You have given us very constructive and helpful suggestions. We appreciate it very much.

[Dr. Wycoff's prepared statement follows:]

STATEMENT OF SAMUEL J. WYCOFF, DDS, PROFESSOR AND CHAIRMAN OF THE DEPARTMENT OF PREVENTIVE DENTISTRY AND COMMUNITY HEALTH, UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

The potential effectiveness of preventive measures is greater at this time in dentistry than in any other health field. The technology now exists to virtually eliminate the two major dental diseases in the United States -- dental caries and periodontal disease. Yet both problems remain rampant in this country. Dental caries affect more than 95% of the population. Roughly 80% of all middle-aged adults have destructive periodontitis. Nearly 50% of all Americans aged 65 and over have lost all of their teeth. Indeed dental disease is the most widespread degenerative disease in the United States.

The question is: why? If the two major forms of dental disease are in fact preventable, why are we not preventing them? If pain, altered appearance, loss of function, poor dietary habits, and more serious problems caused by dental disease affect both the health and the quality of life of so many Americans, why are we not acting to change this circumstance?

The answers to these questions are complex. They are bound-up in the attitudes and actions of individuals, the dental profession, and the government. Individuals of all ages are often uninformed about dental disease and the need for effective oral hygiene. One study of American adults revealed that only 24% had ever heard or read about dental plaque, and only 20% had ever been shown at a dental office how to make sure that they were cleaning their teeth correctly. Another study showed that only 40% of those interviewed had ever attempted flossing. Knowledge of dental facts, however, does not always lead to appropriate action. Poor response to dental health education is generally attributed to beliefs about the likelihood and seriousness of dental disease. Recent surveys have shown that tooth decay is viewed by the general public as very likely, but

not serious. Gum disease, on the other hand, is perceived as fairly serious but not very likely. Although most of the people surveyed believed that dental disease could be prevented, there was little connection in their minds between prevention and regular dental examinations. Only 50% of the total survey sample believed that regular dental visits and early detection were of value. The problem, however, does not rest entirely with the individual.

The dental profession is the chief channel of information regarding state-of-the-art preventive measures. Indeed members of the dental health team have been instrumental in both developing and promoting preventive technology. Water fluoridation is a case in point of strong professional support of a preventive measure at the public health level. Yet adequate data are lacking about the nature, extent, and effectiveness of preventive practices in private dental offices.

At the present time the key measures in primary prevention are fluoride therapy, mechanical prophylaxis (brushing, flossing, professional scaling), dietary modification, pit and fissure sealants, early orthodontic adjustments, and patient education and motivation. In addition, early detection measures such as orthopantographs (x-rays revealing orofacial abnormalities and bone lesions), thorough soft tissue examination, head and neck lymph node palpation, and pulse and blood pressure readings are becoming recommended dental practices.

Undoubtedly all of these preventive measures are not employed with equal frequency in all dental offices. A national survey supported by the National Institute of Dental Research has shown that dentists have increased their use of topical fluorides, and that they show concern for oral hygiene and improving patient attitudes toward routine and preventive dental care. While dental schools and continuing education curricula now emphasize such measures, indications are that patients and

third-party carriers are not yet willing to pay for them.

At a governmental level dental health is perennially a low-priority issue. Pushed off center stage by apparently more serious, more pressing, and more "emotional" or "popular" health issues, dental health has received only passing attention in several areas, including the provision and financing of dental services, the protection of the consumer in such areas as food content and food labelling (particularly with regard to sugar), and the allocation of resources for dental research. In debates about services to be covered under national health insurance, again dental services seem to have assumed a low profile in comparison to medical services.

It is gratifying to me that the proposed "Maternal and Child Health Care Act" has particular provisions for regular dental care and for preventive and diagnostic dental services for children over age three. I have several comments about the bill itself which I feel might strengthen it.

(1) I feel a person with dental expertise and knowledge should be specifically identified in the administrative unit.

(2) A built-in incentive such as grants-in-aid for communities to purchase fluoridation equipment would go a long way in furthering this important preventive measure.

(3) Reimbursement to schools on a capitation basis for participation in preventive programs such as fluoride rinse programs and deplaquing programs would be a significant incentive for them to initiate such programs.

(4) A waiver of the co-payment requirement for children who participate in these school-based preventive programs would, in my opinion, be a desirable component.

(5) Payment for emergency dental services for children under age three would be a desirable inclusion.

(6) Reimbursement for dentists who participate in the repair of congenital deformities in team programs for children under age three would enhance these very important reconstructive programs.

I feel this legislation if enacted would go a long way toward alleviating many of the general health problems experienced by pregnant women and children and would be a decided step forward in preventing and treating the many dental ills which I have cited. I would like to express my support for this bill, Mr. Chairman.

Mr. SCHEUER. Ms. Spain.

STATEMENT OF CAROL SPAIN

Ms. SPAIN. My name is Carol Spain. I am the administrative dental hygienist of the Dental Health Bureau for Alameda County Health Care Services Agency in the East Bay area. I think that Dr. Wycoff and I both agree that this bill, if enacted with adequate dental provisions, would have a major effect on the oral health of children in the United States. I think that dentistry is one of the health fields that would benefit greatly by adequate preventive health services at early ages. We know now that we can virtually eliminate peridontal disease and dental caries if we start early with diagnosis and early treatment of small carious lesions in children.

Small carious lesions, dental decay, small areas of dental decay. Now, admittedly, you can't just set up services and not have educated parents and educated children to utilize services. I think a major part of setting up dental provisions for prevention would be in having adequate health education programs for parents and children. In Alameda County I have been the administrator of a number of dental programs. One program we have has 33,000 children in elementary school. This program is called the dental disease stop program.

In that program, we have done a number of dental screenings. Some of our findings are as follows: By kindergarten, through just a visual exam, we have found that 32 percent of the children need dental care. By sixth grade, 46 percent of the children are in need of dental care. This is without X-rays. By high school the prevalence of dental problems is greater. We have a program now where we have 4,000 junior and senior high school students in Oakland that we are screening and we have found that virtually 80 percent of them are in need of dental care.

The high costs of dental care in treating tooth decay becomes much more costly as children become adolescents. The carious lesions, if previously untreated have become more extensive. There is a good chance that teeth will be lost and time will be taken out of school for dental appointments. Extensive dental health problems can definitely affect the individual's appearance, and possibly their employability. We have a lot of research that we use to motivate our schools and our community to start preventive dental programs. In Alameda County, we have been fortunate in that the county board of supervisors has allocated $42,000 to start a school-based preventive dental health program. In this program, not only are we dealing with health education, but we are instituting topical fluoride mouth rinse programs in elementray school classrooms which have been shown to reduce dental decay by 30 to 50 percent.

We have shown that our program can improve the attitudes of the children, and can improve the gingival health of the children. We know that with topical fluoride, the incidence of carious lesions in the participants will be reduced by 30 to 50 percent. I think that if we can have adequate dental coverage for children beginning at age 3 within the Maternal and Child Care Health Act as part of a national system of health care benefits, that this would motivate families to seek preventive dental care for their children. The professional coverage in the bill should cover endodontic treatment as well as early restorative treatment. It is important that this is done, as

Dr. Wycoff mentioned, for deciduous teeth. Often a child will fall and injure their teeth and it is important that these teeth be kept in place so that the permanent tooth has adequate space for eruption. Otherwise, the child may develop orthodontic problems.

Also in a bill of this sort, hopefully there will be some provision for some early orthodontic intervention to help prevent early loss of deciduous teeth as well as to guide permanent teeth into place.

We know that dental care costs are really skyrocketing. So far, besides some of the provisions in medicaid which only affects a small portion of the population, there really are inadequate dental programs and services for a large portion of the population. In Alameda County, we have 1.1 million residents. Approximately 12 percent of the population is on medicaid and an additional 12 percent of the population are considered low income with inadequate resources for dental care. As we go into the schools and we begin screening children and making referrals for dental care, we have a lot of problems getting the children to care because the families are caught right in between not having medical coverage and not having adequate resources for dental care. Taking care of dental problems is costly and often viewed as a low priority for the family budget. Again, we need educational programs so that families can realize that dental care and dental health are part of total body health. We know that later on as individuals become in need of dental care or lose the function of their teeth as they get older, that their poor state of dental health does very much affect their total body health by interfering with their ability to properly digest food.

Mr. SCHEUER. I recall in the early days of the poverty program, they found that when young people went into the Youth Corps at 17 and 18 that they had to give up buying red meat, steak and chops. They had to give them only hamburger because a large percentage of these kids have never had any dental care. Their mouths were so diseased that they couldn't bite into a piece of meat that wasn't already ground up for them. I remember hearing that testimony 10 years ago.

Ms. SPAIN. What was the age of these individuals?

Mr. SCHEUER. Probably 16, 17, 18.

Ms. SPAIN. We are finding very severe dental problems in the low income adolescents in Oakland. It is quite shocking. We know that this will affect their total body health later on. If they are in medicaid later as adults and go in for care, it can be very, very costly. Right now, in the United States, $7.5 billion are spent annually on dental care. In California in 1977, $110 million were spent in the Denti-Cal program. Again, in dentistry, we have cost-effective dental program models. Our school health program costs only $1.28 per student per year. If we can reduce dental decay by 30 to 50 percent, and the average child has one new cavity per year, and the approximate cost of a filling is $15, the savings would be $5 per child per year versus $1 to $1.50 per year for preventive programs. We have proven preventive dental measures, and we certainly hope that a bill of this sort will include them in the scope of dental professional coverage made available to children.

Regarding dental professional coverage for pregnant women, it would be recommended that during the pregnancy at least one dental

examination and/or prophylaxis be included in your coverage of professional services. This would be an opportunity to give some health education to mothers regarding dental care for children, the use of fluorides or additional fluoride therapy when the community does not have fluoride in the water supply, the need to get the child to the dentist after the deciduous teeth have erupted, what to do when there is an accident to a deciduous tooth, and the need to repair and treat the early lesions in deciduous teeth.

Many parents are not aware that even though the deciduous or baby teeth fall out that there is still a need to treat and restore them and keep them in the mouth until they are ready to be exfoliated to come out.

During the second month of pregnancy, elevated female hormones often result in an increase in gingival inflammation and gingival problems in women.

Mr. SCHEUER. You will have to explain that to me.

Ms. SPAIN. The gingiva is the tissue around the teeth that supports the teeth. Periodontal disease is the inflammation and infection of the gums and the bone. Periodontal disease is the major cause of tooth loss after the age of 35.

Dental caries is much more common in children and the caries peak rate is in the adolescent years, so I am glad to see that this coverage would continue until the age of 18. After the age of 35, the major cause of tooth loss is actually periodontal disease. We find that gingival problems usually begin in the adolescent years, but sometimes as early as age 7 or 8 in children that are not keeping their teeth adequately clean. Many people are not aware that tooth decay and periodontal disease are caused by a bacterial film on the teeth called plaque.

Health education is important. I think if you had one session, at least, for a mother during her pregnancy that we could begin to do some needed parent dental health education.

[Ms. Spain's prepared statement follows:]

Testimony on H.R. 1702, Maternal and Child Health Care Act
Presented Before
U.S. House of Representatives
Subcommittee on Health and the Environment
Of Committee on Interstate and Foreign Commerce

January 5, 1978
San Francisco, CA
by

Carol Spain
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I would like to express my appreciation for the invitation to testify before you today on the Maternal and Child Health Care Act, H.R. 1702.

I am especially interested in this bill because of the inclusion of provisions for children's preventive dental health services and dental professional services for pregnant women and children. At the governmental level dental health is perennially a low-priority issue: Yet oral health problems are prevalent in 95% of the population often leading to pain, altered appearance, loss of function, poor dietary habits and more serious problems that affect an individual's total body health, employability, and quality of life.

My remarks are intended to add to those made previously by Dr. Samuel Wycoff of U.C. San Francisco and will address the following areas:

1) Statement of the Problem - U.S. dental health statistics and recent findings of school dental screening and referral programs in Alameda County.

2) Recommendations for preventive and professional dental services for pregnant women and children to be covered in the scope of H.R. 1702.

Dental Disease is the most widespread degenerative disease in the U.S. In spite of the fact that the effectiveness of preventive dental measures have been proven and that significant advances have been made in the diagnosis and treatment of dental disease, it is disturbing that:

- approximately one-half of all children in the U.S. under the age of 15 have never had dental attention.

- approximately two-thirds of all children from families with incomes of less than $4,000 have never received dental care.

- dental caries affect more than 95% of the population.

- there are over one billion unfilled cavities in the U.S.

- ninety-five percent of the adult population has some form of periodontal disease.

- nearly 50% of all Americans aged 65 and over have lost all their teeth.

In my current position as Administrative Dental Hygienist of the Dental Health Bureau of the Alameda County Health Care Services Agency, I am acutely aware of the prevalence and severity of children's and adolescent's dental health problems in our community. The findings of the Alameda County Child Health Disability Prevention Program, our County E.P.S.D.T. Program, indicate that dental problems are one of the most common health problems of children screened. Through our elementary school-based dental prevention program in the Alameda County Schools, entitled the Dental Disease Stop Program, our dental screenings on a sample of students indicate that:

- 32% of the children need dental care by age 5 (kindergarten) and

- this figure increases to 46% by age 11 (6th grade).

In a sample of elementary schools in Oakland, California, there was an average of 350 children per year who visited the school nurse with a toothache complaint and on the average, 30% of these children were considered low-income and not covered by Medi-caid.

By junior and senior high school, the time of the adolescent' caries attack peak, our dental screening and referral program for 4,000 students in Oakland Unified School District indicates that approximately 80% of students are in need of dental care. 20% of these students do not have access to dental care. They are low-income, are not covered by Medi-caid and have no other resources for adequate dental care.

Dental care costs rise each year. An annual expeiditure for dental care in the U.S. already is in excess of 7.5 billion dollars. In 1977, California alone spent $110 million in the Denti-Cal Program. Yet the technology now exists to virtually eliminate the two major dental diseases in the U.S. - dental caries and periodontal disease. A system of national health care benefits established for children and pregnant women in the U.S. as proposed by H.R. 1702 that has provisions for providing adequate preventive dental health services for children including provisions for the early diagnosis and treatment of dental problems would significantly reduce national costs for dental care and improve the overall health of our children.

Specifically, in Part B of H.R. 1702 - Children's Benefits - Covered Professional Services - services for children aged 3-18 should include

1. Provisions for supporting the funding of school-based preventive dental health programs to include health education instruction, deplaquing and topical fluoride programs. School-based topical fluoride mouthrinse programs have been shown to reduce dental caries by 30-50%. In Alameda County only approximately 20% of elementary school aged children are in our D.D.S. Program because of limited funds, yet our program has been shown to be effective in improving the knowledge and attitudes of students and in decreasing their dental caries and gingival disease experience. The cost is only $1.28 per student per school year.

2. Fluoride supplements for patients in non-fluoridated areas or economic incentives to non-fluoridated areas to institute fluoridation of public water supplies.

3. At least annual dental examinations and oral prophylaxis including topical fluoride applications.

4. Restorative treatment for carious lesions including endodontic treatment of deciduous and permanent teeth.

5. Early orthodontic intervention, space maintainers and athletic mouthguards, when necessary.

In Part C - Maternity Benefits - Covered Professional Services - provision should be made to provide an oral examination, dental health education session and oral prophylaxis including root planing as necessary, after the second month of pregnancy when elevated female hormone levels result in increased levels of gingival inflammation and gingival disease in many pregnant women.

Prevention and early intervention and treatment of dental problems is the key to improving the oral health of our children. Early restorative care is actually preventive care in that it is <u>essential</u> if the degenerative effects of dental disease and the high costs of later extensive dental care are to be avoided. Emphasis on early intervention and prevention will help instill positive attitudes in children towards their oral health, preventive health behavior and utilization of dental services as adults. By decreasing their experience of dental pain and fear as children, we can avoid the negative effects such experiences have on their attitudes as adults towards their oral health. Any proposed system of national health care benefits for children must include adequate preventive dental services if the system is to deal effectively with the <u>total</u> health needs of our children, the future adults of our nation.

Mr. SCHEUER. I think I am ready for the title of "dentist extender" after this education.

Dr. WYCOFF. It is certainly one of the most controversial issues in the dental profession right now. We don't call it "dentist extender," we don't like the term.

Mr. SCHEUER. What do you call it?

Dr. WYCOFF. We call it an expanded duty auxiliary or an expanded function auxiliary, EFDA.

Ms. SPAIN. We have dental paraprofessionals doing more and more work, dental hygienists and dental assistants.

Dr. WYCOFF. Technicians are the people who make artificial dentures.

Mr. SCHEUER. Again, in the military, isn't routine dental work, cleaning and all that, done by dental hygienists?

Dr. WYCOFF. I doubt that Ms. Spain would call dental hygiene routine dental work, but that is done.

Mr. SCHEUER. What is the controversy in the dental profession?

Dr. WYCOFF. Many dentists are opposed to having dental assistants or hygienists do some of the things that the dentist has been doing in the past, much like the physician controversy. I think we are a little bit farther behind the physician as far as the controversy is concerned. The dentists feel that these are their guarded rights and that no one else should do them.

Mr. SCHEUER. What kind of things are you speaking of?

Dr. WYCOFF. The thing that is probably the most controversial is the putting in of fillings. The dentists don't mind letting someone else do the cleaning of the teeth and some of those sorts of things, but the putting in of fillings, which in my opinion is not that great a deal, is very much opposed by many dentists. I feel that it is much more important to be able to do a diagnosis and a treatment plan and coordinate the treatment than to put in a rather simple filling. I feel differently, of course, about making a cavity preparation where you cut the cavity for the filling. I do feel that that requires the skill of a dentist. I think one can be taught very quickly to put in a filling. It doesn't take 8 years of extensive and sophisticated training.

Ms. SPAIN. Many of the preventive professional services that a bill like this might be delineating except for the actual cutting of the tooth structure and possibly the placement of restorative materials in teeth will probably be done by dental paraprofessionals and not at the high cost of actually paying a dentist. For example, dental hygienists are very involved in dental examinations, diagnoses and assisting the dentist in developing treatment plans. The administration, planning and implementation of a lot of these preventive programs in schools are done by dental paraprofessionals.

Dr. WYCOFF. We have just begun a rather extensive multifaceted preventive program in Hayward, Calif., in which most of the preventive procedures are being done by dental hygienists and dental assistants under the general supervision of a dentist. It is primarily a cost effectiveness type of program because we have already determined the efficacy of the preventive aspects, so it is being done, certainly, and I think it is being done by the proper people.

Mr. SCHEUER. Any questions? Dr. Bruyn?

Dr. BRUYN. I have always thought that dentists were further ahead of the medical profession in their use of dental hygienists as a

dentist's assistant. The dental hygienists in offices that I know of charge a fee and get paid that fee which pays the dentist a portion for the use of the space and the equipment. That is an ideal sort of an example for the physicians' assistant. I know of one pediatric office in San Francisco that is using a pediatric nurse practitioner in just this way. She gets paid for each examination that she does and a portion of that fee goes to the pediatrician.

Mr. SCHEUER. She gets reimbursed directly?

Dr. BRUYN. Her bills go through the same procedure that his do and a portion of that, then, is retained for the use of the space, equipment, and so forth.

Dr. WYCOFF. That is illegal by dentists and dental hygienists in the State of California. There is a case before the board now that is contesting that because there is a hygienist that has opened as a self-proprietor, for example, essentially what you have described, and the board of examiners is questioning that very severely. As far as I know, this is the only case in California. I am sure there might be some that are under the table, but it is illegal for a hygienist to be a sole proprietor. He or she can participate in either a percentage or a salary, but not a sole proprietor where he or she collects the fees independently. That is against the law in California and most other States, to my knowledge.

Ms. SPAIN. Usually, what does happen is there is a commission basis worked out for each fee, each patient that the hygienist sees.

Dr. BRUYN. That's probably what I am talking about.

Ms. SPAIN. Right. Basically, the patient pays the dental office and the hygienist gets a certain percentage of the gross fees that she brings in on a certain day.

Dr. WYCOFF. But the fee is billed by the dentist.

Ms. SPAIN. Right.

Mr. SCHEUER. Thank you very much. It was very interesting.

Now we have our last panel, Dr. Roderic Phibbs, associate professor of pediatrics at the University of California and Dr. William Tooley professor of pediatrics, also at the University of California.

Your prepared statements will be printed in full in the record so you can simply chat informally with us. Dr. Budetti and Dr. Bruyn are here. At the end of your testimony, we would be happy to have them address any questions to you that come to mind.

STATEMENTS OF RODERIC H. PHIBBS, M.D., PROFESSOR, SCHOOL OF MEDICINE, UNIVERSITY OF CALIFORNIA, SAN FRANCISCO, AND WILLIAM H. TOOLEY, M.D., PROFESSOR, SCHOOL OF MEDICINE, UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

Dr. PHIBBS. Thank you. I am Roderic Phibbs, professor of pediatrics at the University of California, San Francisco. Dr. Tooley and I prepared a formal statement and I would like to just briefly run through the main points in it, which emphasize, at least in our view, the very extreme importance of the bill which provides health care insurance for pregnant mothers and newborn infants.

I suspect you all know at this point that the neonatal death rate in the United States is 10 per 1,000 live births. It is a widely quoted figure, usually quoted in the context of pointing out that this is ranked

very low down compared to neonatal death rates in other highly developed nations. It means that 1 out of every 100 newborn babies is going to die before he or she reaches 28 days of age, generally in the first few days of life.

The mortality rate is, in fact, only an indicator of the problem and it doesn't really give a full measure of how great a problem this is. The reason for that is that the diseases or disease processes that kill some of these babies maim others who will survive but be permanently handicapped with brain damage.

The commonest causes of these kinds of injuries are various forms of the failure of the respiratory and circulatory systems, often from prematurity or other causes such as major infections, congenital malformations and birth trauma. We cannot prevent all of these, but with new systems of care that have been devised during the past 8 to 10 years, the vast majority of these can now be successfully treated, and this is the point.

This system of care is a combination of pediatrics and obstetrics and it has been referred to as perinatal care, neonatal care, neonatal intensive care, or perinatology. All of these terms are thrown around and they all mean more or less the same thing. They are, to some extent, what you called earlier "crisis care," but really they are preventive care in many ways. This care can prevent much disease, and when it cannot prevent disease, it can successfully treat disease and thereby prevent its long-term consequences. A case in point is hyaline membrane disease. This is the cause of respiratory failure in the first days of life. Until recently, it was the single commonest cause of death in newborn infants. It killed about 60 percent of the babies that it affected. You probably know it best as the thing that killed the late President Kennedy's son, who was born somewhat prematurely.

New methods of early management of pregnancy can prevent something like 25–50 percent of these cases. Of the children who get it, the mortality rate using the new methods is now down to 15 percent from 60 percent. That means that applying this system of care, at least to this condition, gets you to salvaging five out of every six infants who would have died only 6 or 7 years ago.

That is all well and good, but that is mortality and I think you would probably immediately say, "What does it do for morbidity in the long-term survivors?". If this is going to be successful, that is where it has to make itself known.

Mr. SCHEUER. What is the technical definition of morbidity?

Dr. PHIBBS. Morbidity, as I am using it, means any——

Mr. SCHEUER. Is it a rate of sickness?

Dr. PHIBBS. No; I'm sorry, let me retract that and say that what I really mean to say is to look at whether or not this disease prevents permanent handicaps among the survivors because it does no good if we save babies but they are damaged. We recently compared the incidence of handicaps in a group of prematurely born infants. These are the ones most prone to handicaps in previous times. It would seem that when one compares the incidence of handicaps in infants born in the fifties with those born after the mid-sixties, provided that they receive this specialized system of care, the incidence of serious debilitating handicaps—cerebral palsy, mental retardation,

blindness and deafness—is down to about one-fifth what it was in a previously treated group. This is probably the more important point for this care.

I need hardly say that this fairly is complex care. It requires specially trained people and it requires special facilities and it is expensive. Therefore, a variety of national organizations of experts that have looked at this have suggested that this care should be delivered within the context of the system of regionalization for perinatal care. There is some mention of this in the bill and I hope that this would be strongly emphasized. This doesn't mean that every baby needs to be delivered in a highly complex hospital. It means a process of selection and integration of various services moving the patient to the level of care required.

Mr. SCHEUER. What do you think about home births?

Dr. PHIBBS. There is one problem with home births, and I am afraid there is no getting away from this. Home births can be very successful by and large when they are incorporated in a system of regional care where physicians and midwives carefully screen the patients and select out all the problem patients and keep only the healthy, which are the majority.

Mr. SCHEUER. I wouldn't suggest it for any cases where you could reasonably expect complications.

Dr. PHIBBS. A small percentage of complications which can be disasters will occur so late that there is going to be no way that you can move them. If you accept home deliveries, you must accept that a certain amount of morbidity or permanent injury and death will occur, which could be prevented in a proper, well-run delivery service. There is no getting around that. You can keep it to a minimum, but there are going to be some cases. The exact number I can't give you because we have not enough experience well documented with home deliveries.

Mr. SCHEUER. Up until very recently, weren't most births delivered at home?

Dr. PHIBBS. That's right.

Mr. SCHEUER. I was born at home and I have four brothers and sisters that were born at home.

Dr. PHIBBS. The problem is that nobody was keeping these kinds of complete records in those times and until very recently we have not had good records on what the outcome is.

The point about regionalization is that it makes available to those who really need it this specialized care, but it also makes efficient use of what are very expensive resources. If you like regionalization allows you quality control and cost control. If there is to be support for this care, it really must be emphasized that it must be administered within a system of regionalized care.

Mr. SCHEUER. How far would you send a prospective mother if you felt some complication was reasonably predicted?

Dr. PHIBBS. There is increasing experience with this, and mothers with very complicated babies, where both the mother and baby are seriously jeopardized, can be moved even when they are in early labor as much as 150 miles or more and we do this fairly regularly. It depends upon a system of close coordination between the tertiary center and the community hospital, but with good communications this can be done successfully and is being done regularly.

Dr. TOOLEY. And mothers, before labor begins, have [illegible] to come 500 to 1,000 miles to have their infants delivered if they suspect that the infant will have a special problem which can be dealt with only in one spot.

Mr. SCHEUER. Would that be by air?

Dr. TOOLEY. This is before labor would begin. This would be a woman who was herself sick and for a good reason was expecting a very sick infant, and would choose to have her medical care provided at a place where both she and the infant could get the maximum benefits. This is a maternal decision much more often than medical because obstetricians often resist their patients moving that far from their purview, but, again, with education it seems to me that the mothers are quite willing to undergo what is a traumatic family disruption in order to benefit the child.

Mr. SCHEUER. Somebody mentioned here, how about educating the providers? I guess that is going to take some educating of the pediatricians.

Dr. TOOLEY. I would say that it was the obstetricians that needed it in that context. It may be pediatricians, too.

Dr. PHIBBS. That is what I meant by regionalization, because a true system of regionalization, and there are very formal recommendations of what regionalization means which I can give to you if you like, requires education of the health care providers throughout a region. It requires, in fact, that records are kept and review of performance to see that people are really performing at the level they should be performing. There are systems of evaluating just how well health care is being delivered to pregnant women and newborn babies, so this is why regionalization is important. Regionalization, I might say, is not here. It doesn't exist in all areas. A comprehensive program of regionalized perinatal care doesn't exist at all in large parts of this country. Some areas have fragments of it and they are better off than with nothing, but one doesn't have there the kinds of spectacular successes that I have cited for you.

Mr. SCHEUER. Do you think this needs a legislative format to encourage it? Could you go forward under a sort of regionalized modality or do you need some sort of recognition for the need for it?

Dr. PHIBBS. I think there needs to be a certain amount of legislative force behind this. There is some. There are now Federal guidelines for HSA's for health care planning and they have strong recommendations about a system of regionalized care, so that will be effective provided the HSA's themselves have any teeth and any force, if they follow those guidelines. We have almost gotten a complete system of regionalized care in a couple of areas of the country, including in California, in parts of California.

I wouldn't suggest we have it across the board. This has only come about, I might say, with extra outside funds from the National Institutes of Health and other specialized forms of funding such as the crippled children's services. At least, in the crippled children's services in parts of California they have been the people that have enforced quality control, and through quality control enforced education. They have specific standards of all the relationships that must exist within a system of regionalization to enforce a referral of certain kinds of conditions. There is where they have gotten, at least in that mechanism, the quality control.

Mr. SCHEUER. How do you define a region? Is it geographic, is it population, is it health facilities or what is it?

Dr. PHIBBS. That is difficult. It has to be defined partly in terms of population size, because there has to be a minimum population to make these kinds of facilities practical. The Federal health guidelines have made a stab at that, a reasonably good stab.

Dr. TOOLEY. I think the 220 health service areas which are geographic are probably as close as you are going to get. There have to be provisions for some stretching and squeezing to accommodate local population consideration. In general, I think those are the regions that we would be happy with.

Dr. PHIBBS. The last point I would like to make is that—to reinforce something I suspect you already know—which is that this care is very expensive in the shortrun but a benefit in the long run. For example, when preventive care doesn't work and a baby is born prematurely and has lung disease, it is going to cost about $15,000 to take care of that baby. Now, that sounds like a lot. On the other hand, it costs anywhere from $8,000 to $24,000 per year to rehabilitate and care for a seriously handicapped child, and that expense goes on year after year after year. That is the worst. The less severely handicapped, although they don't have those kinds of expenses, have a lifetime of unproductive activity, essentially on welfare much of the time. In the formal handout, we have made some estimates of what it will cost and what will be saved in the long run for a very high risk group. The initial expenses are pretty considerable, but I think it is pretty clear that just in direct costs saved for rehabilitative programs for the handicapped one will more than get back those costs in the very near future. That doesn't begin to talk about indirect costs of lack of productivity or the prevention of human suffering. To our mind, a bill such as this that provides that kind of care and provides it according to strict regionalized guidelines is going to be an immense benefit to mothers and children.

Mr. SCHEUER. What do you specifically recommend that we add to this bill to provide for proper regionalization programs? Is anything necessary? Could it be done with the language that you see before you?

Dr. PHIBBS. I am not completely sure. I think that would depend on how effectively the Federal guidelines to the HSA's are enforced. If they are enforced, then the bill as it stands will be adequate. If they are not enforced, then I feel that it should be required that care be provided within a system of regionalization. I realize the bill says that, but I am not quite sure it says it in firm enough and strict enough terms, in terms of perinatal care. If you want to see the guidelines for perinatal care, I have a copy I can leave with you.

[Dr. Phibbs' and Dr. Tooley's prepared statement follows:]

THE IMPORTANCE OF COMPREHENSIVE HEALTH INSURANCE FOR CARE OF PREGNANT MOTHERS AND NEWLY BORN INFANTS

Roderic H. Phibbs, M.D., Professor, School of Medicine, University of California, San Francisco

William H. Tooley, M.D., Professor, School of Medicine, University of California, San Francisco

At present the neonatal mortality rate in the United States is 10 per 1,000 live births. This means that one out of every 100 babies born alive dies before he or she reaches 28 days of age and most of them die within the first week of life. This neonatal mortality rate is substantially higher than that of most of the highly industrialized nations of the world and is one of our most important health problems. However, the mortality rate is only an indicator, not a true measure of the full extent of our failure to provide adequate medical care for the unborn and newborn infant. The same disease processes which if untreated, kill some infants, leave many more infants permanently injured with brain damage.

The commonest cause of death and permanent disability in the perinatal period is temporary failure of the circulatory and respiratory systems from a variety of causes including prematurity. Other important causes include infections, congenital malformations and trauma during labor and delivery. Some of these are untreatable but the majority can now be treated with remarkable success by a new system of care that uses a variety of methods developed over the past decade.

This is a combination of obstetrics and pediatrics and is variously called neonatal intensive care, perinatal medicine or perinatology and it is able to prevent much disease and successfully treat much of that which can't be prevented. Hyaline membrane disease is a case in point. Until 6 years ago this particular form of respiratory failure killed 60% of the infants it affected and was so common that it was the leading cause of neonatal death. You may know it best as the cause of the death of the late President Kennedy's son. New methods of prevention can reduce the incidence by 25 to 50% and new methods of treatment can reduce mortality among those affected from 60% to 15%. The combined effect is the salvage of 5 out of every 6 infants who would have died of the disease 10 years ago.

For this system of care to be truly successful it must reduce the incidence of handicaps among survivors as well as increasing their numbers. Here too perinatal care has succeeded. This can be seen by looking at the incidence of handicaps such as mental retardation, cerebral palsy and loss of hearing or sight among prematurely born infants, where these problems were frequent in the recent past. A comparison of infants born prematurely in the 1950's with equally premature infants who were born in the late 1960's or later who received this specialized care shows the latter group has only one fifth as many with serious handicaps. The table shows the details of this comparison.

INCIDENCE OF HANDICAPS IN PREMATURELY BORN INFANTS

Birth Weight	% of Survivors with a Moderate or Severe Handicap on Follow-up		
	1950's	1965-70	1971-76
950/1150 gm	70%	27%	14%
1150/1350 gm	41%	14%	9%
1350/1500 gm	35%	14%	6%

Degree of prematurity is indicated by birth weight. 950-1150 gm, is equal to about 2 pounds; 1150-1350 gm, to 2-1/2 pounds and 1350-1500 gm to 3 pounds. For comparison the normal birth weight for a full term infant is 3000 gm or 6-1/2 pounds. The patients from the 1950's are from Denver, Colorado (see Lubchenko, et. al., Journal of Pediatrics, Vol. 80, page 509, 1972). The patients from 1965-70 are the first 5 years during which special perinatal medicine was being phased in at the University of California, San Francisco. The patients from 1971-76 are from the same institution when perinatal medicine was more highly developed. The criteria for "moderate or severe handicaps" are the same in all 3 groups.

The recent trend of increasing success as perinatal care is applied more completely plus the continued development of more new methods of treatment suggest that both the numbers and quality of survivors will continue to increase in coming years.

Modern perinatal care is relatively complex, requires teams of highly trained medical personnel and specialized facilities so it is relatively

expensive. National organizations* of experts have all suggested that programs to deliver this care should be developed within a system of regionalization. This would insure that the complete system of care was applied to all that could benefit from it and that care would be made cost effective through efficient utilization of these specialized and expensive resources. Regionalization allows cost and quality control. This has not yet happended throughout the United States. Some areas only have access to the older, less successful forms of care. Others have access to certain components of the system of modern perinatal care and, while this is an improvement the results are not the spectacular ones we cited earlier. There are some areas that have a complete system of care because specialized services were developed with funds from the National Institutes of Health or some other specialized method of funding. A few areas even have a redundancy of some components of the system of care because of a lack of regional planning in the past. We seriously doubt this system of care will be applied generally and wisely across our nation until there is broad financial support for regionalized perinatal care.

This care is expensive but the ultimate economic and social benefits far outweigh the initial costs. The cost of long term care for a seriously retarded or crippled child is far greater than the cost of the initial care which can prevent these handicaps. The greatest costs in perinatal care occur when preventitive measures fail and an infant requires the maximum level of neonatal care. The average costs for such an infant are approximately $15,000. On the other hand, it costs between $9,000 and $24,000 yearly for the care of a badly handicapped child and this expense goes on for years. Those with less severe handicaps also represent a great loss in productivity which continues for a life time during which they are

*See Standards and Recommendations for the Hospital Care of Newborn Infants, 6th ed. American Academy of Pediatrics, P.O. Box 1034, Evanston, Ill. 60204

unemployed and on the welfare roles.

Failure to provide comprehensive health insurance for perinatal care can also cause another social and financial loss even in communities where modern care is available. The parents of sick infants are young couples just beginning to establish their financial self sufficiency. When they are burdened with large hospital bills at this point in their lives they often back slide onto the welfare roles.

It is impossible to estimate precisely the total costs and full benefits of providing modern perinatal care to the nation but we have estimated costs and benefits for one group to serve as an example. Consider 150 infants born very prematurely and weighing between 1,000 and 1,500 grams (2 to 3 pounds) at birth. With traditional care approximately 50 will die in the first weeks of life, 50 will survive and be normal and 50 will survive but be significantly brain damaged. The ultimate cost of custodial and rehabilitative care for the last 50 throughout their lifetimes will be approximately 24 million dollars. If the full range of modern perinatal care were applied to the same group, premature birth and its major consequences would be prevented in 50 who would then be normal. The other 100, would require neonatal intensive care and of these, 25 would die, 10 would be significantly damaged and 65 would be normal. This gives 115 as opposed to 50 normal children and 10 as opposed to 50 damaged. The increased medical expenses would be approximately $1,500,000 but the long term saving in care of the handicapped would be approximately 19 million dollars so that the costs of perinatal care would be recovered within just 2-1/2 years. Now consider that the example of the 1,000 to 1,500 gram premature occurs 1,200 times not 150 times each year in our country and you will have some idea of the direct benefits. Then remember that we have only estimated direct costs and benefits, not the indirect benefits that come from each normal child who grows up to be a productive citizen or the incalculable benefits of preventing human suffering.

Mr. SCHEUER. Very good. Thank you very much.
Dr. Tooley.

STATEMENT OF WILLIAM H. TOOLEY, M.D.

Dr. TOOLEY. I am Dr. William Tooley. I am professor of pediatrics at the University of California. I have a longtime interest in perinatal care and have been a member of the Academy of Pediatrics Committee of the Fetus and Newborn for some 9 years. Our current president Dr. Robinson, testified yesterday.

The Academy of Pediatrics has addressed a number of child health issues over the years through the creation of expert committees to deal with specific areas. The one with which I have been most involved has been care of newborn infants and in that capacity I was the co-editor of these standards which Dr. Phibbs has given you. The standards start out with a detailed discussion of the reasons for having regional care and how regional care might be put together and then it goes on to deal with specific aspects of care for individual infants with a variety of illnesses.

This is the sixth edition of this standard. It has just been published in the last 3 months. In the past, this has ended up as being the basis for the various health codes in States. For example, the fifth edition has been taken verbatim into the California health code, so to some extent we anticipate that these recommendations will end up being enforced on the State levels through the health departments.

I would suggest, however, that this bill would be useful in promoting the general concept of regional care if it included a provision that would permit reimbursement for the care of high-risk pregnancies and sick newborn infants, only if those providers were part of a regional program in order to discourage entrepreneurs and individuals who have in the past set up their own programs outside of regional needs. There is a proliferation of these centers for the delivery of high technological care, often in the absence of any clear-cut need. The regionalization provisions will hopefully attempt to discourage that.

Of additional interest in the standards in the Academy of Pediatrics for hospital care of newborns there is a discussion of who provides the care, and I think the pediatricians have by and large accepted the desirability of having others besides physicians to provide care, particularly in the area of pregnancy and newborn infants.

Mr. SCHEUER. What would you call these people, those other than physicians?

Dr. TOOLEY. Well, I was going to make a comment about how useful it would be to provide education for all the providers in a moment, and I had listed here for that purpose who the providers were. I started with physicians and thought when I came to it I would reverse the order in order not to put the physician in pride of place.

I would begin with nurses and nurse practitioners, who can, through education and during the course of labor and delivery and later care of newborn infants, provide many of the services that are now provided by physicians or not provided at all, which is perhaps least satisfactory

Midwives, I think, can deliver quite successfully and, often, much more successfully, perhaps the majority of pregnant women.

Mr. SCHEUER. Will you elaborate on that when you say "more successfully"? More successfully than the obstetricians? More successfully than whom?

Dr. TOOLEY. Yes, well you can use that if you don't want to be precise. Dr. Phibbs and I deal with that——

Mr. SCHEUER. Wait a minute. You haven't answered my question.

Dr. TOOLEY. I'm giving you a little background before I answer the question. Dr. Phibbs and I deal with that part of the prenatal care spectrum which is concerned with the progress of the newborn during the first days and then later on. We see many instances of babies who have been damaged during labor and delivery, who often, we feel, have been damaged because not of the inexpertness of the the obstetrician but the failure of the obstetrician to be there to assess the situation when he is needed. I think that in many parts of the world where midwives and nurse midwives are delivering all but the most complex cases, that their attention to what is going on in the individual labor is far more intense and, therefore, they are more likely to early pick up abnormalities and institute the appropriate measures to correct them.

Mr. SCHEUER. So you meant more than obstetricians?

Dr. TOOLEY. I meant more than obstetricians who are not present and continuously monitoring the course of the labor. To the extent that obstetricians are present and continuously monitoring the course of the labor, then I think, because generally they have far more experience, they are probably or should be far more likely to do best by the labor and delivery. It is a matter of time distribution.

Mr. SCHEUER. Sure.

Do either of you have anything to say about the health needs and the counseling needs and the preventive health needs of young girls in their very early teens who deliver about 300,000 illegitimate births annually? The number is growing and the average age of these mothers is getting younger. It is the one segment of the female population of this country whose fertility is increasing rather than decreasing. Every other element of the female population is decreasing in its fertility except early teenagers. Do you have any comment about that? I should have asked this question systematically all the way along because I am chairman of a select committee on population of the Congress and we are going to be having an extended set of hearings on early teenage illegitimate births, because these 300,000 births plus legal and illegal immigration seem to be the method of additions to our population.

Dr. TOOLEY. That is roughly 10 percent of the births in this country. The fertility rate—they are not more fertile; it is the fertility rate that is up. Perhaps their chances for becoming fertile have increased in recent years.

I think that in my experience that many of these pregnancies, if not the vast majority, are unwanted so I am led to the conclusion that this is an education problem, primarily, and who should be the educator? Should it be the schools? The schools act instead of the parents in a variety of situations today. I suppose the health educators working through the school system would be the only reasonable approach at this point. Ideally, I suppose, you would like to have health educators working through the parents but I am not sure you have as close a hold on the parents.

Mr. SCHEUER. I suppose you would say a 12- or 13- or 14-year-old girl who became pregnant would be one of these high risk women and would have to be monitored very closely?

Dr. TOOLEY. Yes, and surely one of the tragedies of the increased fertility rate among the young teenage girl is that it is much more likely than the pregnancy in a mature woman to end in a premature birth and perhaps lead to the possibility of brain injury and long term neurological deficiencies adding, if you like, a disproportionate number to the number of births that are abnormal. Also, disproportionately, it adds to the expense of the care which we were talking about. Money that would be spent to educate these girls who don't want the pregnancies, by and large, would be well spent, I think.

Mr. SCHEUER. Peter?

Dr. Peter Budetti, for the record.

Dr. BUDETTI. You mentioned, Dr. Phibbs, that you were fairly well satisfied at least with the beginnings of the plan in the "National Guidelines for Health Planning" for regionalization, but of course the impact of those guidelines is somewhat drawn out. It is not a very clear, precise requirement of any kind. Would you favor using this bill as a mechanism for requiring conformance with the national guidelines for health planning as a basis for reimbursement or for requiring States or Health Systems Agencies (HSA's), to set up regionalized systems before reimbursement could take place under the bill? In other words, using this bill as the vehicle for defining exactly how the other system would work, how the Health System Agency and their attempts to regionalize would have an impact?

Dr. PHIBBS. If I understand you correctly, Dr. Budetti, you are saying that you don't think the HSA's have enough teeth to make regionalization work. If that is what you are saying, then my answer is that something else with teeth better be there—jaws, if you want. I can't think of a better place to have it than in this legislation if, in the judgment of people who know how these systems work, you don't think it is going to come through the recommendation of the HSA. If you don't have a lot more financial support, you are not going to have regionalization at all, because it costs money to develop even a wise and wisely distributed plan. The money isn't there at the moment, except in the special circumstances I cited for you.

Mr. SCHEUER. Where do the States and the counties get the money to draw up their plans, in what piece of health legislation?

Dr. BUDETTI. Were you talking about the National Health Planning and Resources Development Act?

Mr. SCHEUER. Yes.

Dr. BUDETTI. The national guidelines for health planning are required to be issued under that act. A set of standards for health facilities was issued on September 23, 1977, and they were issued as proposed regulations. They did include standards for regionalized perinatal care. Those guidelines were only issued as proposed regulations, and were subjected to mass criticism, and are presently being revised before being issued as final regulations. Those guidelines will only control what Health Systems Agencies must include in their planning. They do not really control what gets licensed, and they have absolutely no control over what is already in place, so that it is entirely up to State law to decide whether something that is already in place at the present time should continue to be there or not. So

what I am saying is, would you suggest using the reimbursement mechanism of this bill or any other bill to put it across? We have a number of expert dental consultants, and if this mechanism is found toothless, you would agree that this is a good place to put it.

Dr. PHIBBS. Yes, I would. This is, in fact, the way that it was done in California in those places where anything like a halfway regionalization system came through. Crippled children's services said, "We will pay you for this care through special moneys made available within California, only if"—and they spelled it out—"these types of facilities, these types of interacting relationships with other hospitals, continuing education provided from the tertiary centers to the community hospitals, and it's got to be there, and you are inspected, and you've got to provide it, and, in fact, your performance is reviewed." In that case it was done through the mechanism of the control of the finances. In addition, to some extent, there was even some control about how many facilities were authorized so there wasn't a great excess or redundancy of specialized facilities, and maximum utilization of the facilities that were there. At least in that example, which may be the best example of what is available in the country, it was done through the purse strings. If you are telling me that the Federal guidelines are going to be followed loosely, then I think this is the place to enforce that type of control.

Dr. TOOLEY. I would add to that, that while there was some success using the moneys distributed through the crippled children's services in providing a regional system in California, it was really not complete or entirely to the satisfaction of those that were interested in having a comprehensive system.

In fact, the State people were under considerable pressures from a variety of groups, some of whom they acceded to, so what they wanted to do, in effect, they couldn't always bring about. In the city of San Francisco, for example, because of the fact that there are long-established hospitals here and a long history of providing obstetrical care plus one medical school and one military hospital for the region, there developed some 6 units for providing intense care for newborn infants, while there are only about 12,000 deliveries in the city of San Francisco. It is estimated that you need a unit of this sort for 5,000 or 6,000 deliveries, so San Francisco at the moment has two to three times as many of these units as it needs. It can only, then, keep these going by becoming the center for a much wider region. There are many other fair-sized communities in this region where similar types of hospitals are planned and which arguably are desirable because they are closer to where the patients are. There are no provisions for closing or limiting the number of units that are already in existence. I think that somewhere there should be legislation which permits a more orderly organization of facilities within a region of one to two million people and which is able to limit the proliferation of hospitals which are unneeded and of providers of other types which are unneeded through the only mechanism I know of, which is the reimbursement, so I would answer Peter's question by saying, "Yes, I certainly would think so."

Mr. SCHEUER. Gentlemen, thank you very much.

This concludes our second and last day of hearings on the Maternal and Child Health Care Act which I and your Senator, Alan Cranston have sponsored, together with a number of other Senators, Senator

Javits of New York, Senator Humphrey of Minnesota, Senator Brooke of Massachusetts, and several dozen Members of Congress.

This is the third set of hearings we have had. We had hearings in New York and Washington prior to this, but I must say that this set of hearings was more informative and stimulating. I want to thank our staff, Director Karen Nelson, for the work that she has done in putting this hearing together, and I want to reiterate my particular thanks to Dr. Peter Budetti, without whose Herculean efforts over the Christmas and New Year's season these hearings could never have taken place.

Dr. BUDETTI. Thank you very much.

Mr. SCHEUER. We are very grateful to you, Dr. Budetti, and I hope you will pass on our thanks to Dr. Phil Lee.

The meeting is adjourned.

[The following statements and letters were received for the record:]

Statement of the

AMERICAN MEDICAL ASSOCIATION

Re: H.R. 1702, Maternal and Child Health Care Act

Submitted to the

Subcommittee on Health and Environment
Committee on Interstate and Foreign Commerce
United States House of Representatives

January 27, 1978

The American Medical Association submits the following comments on H.R. 1702, The Maternal and Child Health Care Act, which is under consideration by the Subcommittee.

The proposal in H.R. 1702 does not differ materially from that contained in H.R. 12937 of the last Congress (94th). As such it has been the subject of an earlier Statement dated July 20, 1976, which was submitted by the American Medical Association to this Subcommittee.

As the Subcommittee is aware, special provision for maternal and child health care is now made under Title V of the Social Security Act. Title V is designed to provide services for reducing infant mortality and otherwise promoting the health of mothers and children; $350 million annually is authorized for this purpose.

Title V is a program of formula grants to states for broad maternal and child health services and crippled children's services. Also included are special programs to reduce the incidence of mental retardation and other handicapping conditions associated with child bearing. Other features of Title V promote the health care, including dental care, of school children and pre-school children of low income families, and support research projects relating to the broad purposes of that title.

The American Medical Association has strongly supported maternal and child health and crippled children's services under Title V. The Association continues in this support and urges that the Title V program be extended and strengthened. In fact the American Medical Association, in conjunction with the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, is developing revisions in the Maternal and Child Health program that would expand the program to address more adequately the spirit and intent of providing maternal and child health care services. After completing final development of these amendments we would be pleased to share with you our recommendations for amending the Maternal and Child Health program.

Essentially, H.R. 1702 would provide no more than the same kinds of service currently available in Title V; however, under H.R. 1702 services would be provided through an objectionable, structured national health insurance program. H.R. 1702 proposes a broad range of health care benefits for all children under age 18 and more limited services to women to accommodate diagnosis and treatment of pregnancy, illness during pregnancy, and illness related to pregnancy for 12 weeks following birth.

It would create in HEW a 3-member Board to administer the program. In the execution of its administrative obligations, the Board could arrange with the Social Security Administration for administration of benefits or could contract with carriers for this purpose. A special payroll tax on employers and employees and a tax on the self-employed would be imposed to finance the program. Title V would be retained, but services eligible for payment under that title would not be reimbursable under H.R. 1702. Such services would also be excluded from coverage under Medicare and Medicaid.

We see no need for the creation of a new maternal and child health care program; and the operation of such a special program under a national health insurance structure would be particularly objectionable. Moreover, the introduction of

H.R. 1702 with benefits parallel to those provided under title V, with a coverage exclusion with respect to services eligible for payment under title V, can only lead to confusion of the beneficiary seeking services.

H.R. 1702 is a program of special application to a limited segment of the population, introducing a new federal health program with detailed and complex controls and administration. It would add a new bureaucracy to be imposed on health care delivery. It would in effect add a Medicare-type program to cover a new segment of the population, but with a special set of benefits and coinsurance rate, new conditions of payment to participating physicians, hospitals, and other institutions, and special reimbursement provisions with respect to drug dispensers. Special hearing examiners appointed by the Board would be employed to resolve questions of eligibility, qualifications of institutions to participate in the program, and the appropriateness of fee and rate schedules.

The American Medical Association opposes the expansion of financing and administration of health care services in the public sector as provided under H.R. 1702. The private health care system in effect in this country, which has provided Americans with the finest health care in the world, is already under threat of deterioration through increasing government regulation. Moreover, as has been amply demonstrated in the past, the government is less efficient than private insurers in the administration of health care programs.

We oppose the imposition of an additional Social Security-type tax on an already heavy tax burden. This is particularly significant when we consider the current state of our Social Security system and the pressing need to provide new financing to avert its bankruptcy. Our Social Security program is presently underfunded. Indeed, it was in danger of being unable to meet even annual pension requirements out of current Social Security income, and this possibility was averted only by the substantial increase in Social Security taxes voted just last month.

Social Security financing for the purposes of H.R. 1702 is also a departure from the original concept of that program whereby those contributing to the program would derive benefits as primary beneficiaries. This is the basis of old age and disability pensions. Under Medicare, too, benefits are extended to the Social Security taxpayer. By comparison, the tax under this bill applies alike to individuals who may directly or indirectly receive benefits under the program and to others who can derive no benefits. Thus, many individuals (single male persons 18 years of age and older) would be required to contribute to the program, yet be ineligible to participate in any of its benefits. This is a distortion and a radical departure from the Social Security taxing principles.

Notwithstanding provision in the bill against government interference in medical decisions, it is clear that certain of the stated requirements would in fact result in interference.

In the interest of patient care, medical judgment must be left exclusively to physicians. The legislative restriction on the performance of surgery to a particular group of physicians, as proposed in the bill, is clearly a government interference with the practice of medicine in violation of this principle and must be rejected.

We strongly disagree with the establishment of fee schedules for physician services. Such schedules for a segment of the population would be disruptive and could operate to limit the availability of health care. They make no allowance for degrees of special skills and could operate to deny to the patient a choice of physician to which he is entitled.

In reference to the requirement in the bill for second consultation as a condition of coverage for certain surgical procedures, we should point out that the Association supports the concept of a voluntary second opinion, with the patient having a choice. When a second opinion program is mandatory, however,

and the patient has no choice, several concerns are raised, including those of unnecessary cost. It must be kept in mind that a conflicting opinion does not itself necessarily establish a lack of necessity for surgery. While any program should recognize the desirability of consultation in appropriate cases, in our opinion consultation should not be mandated as under this bill.

Title V has with increasing success provided maternal and child health care since its enactment. The proposed program is in our opinion duplicative and unnecessary.

The federal government is already deeply involved in a large number of health care programs, each addressed to a different segment of the population. H.R. 1702 would add to this still another program for a special group, providing the national benefits of Title V and full health care benefits to all children under age 18, regardless of economic need.

For example, we have a Medicare program for the elderly and a Medicaid program for the needy. Also there are separate federal programs for veterans (VA), for relatives of servicemen (CHAMPUS), and for Indians (Indian health laws). Still other federal programs provide for treatment in community mental health centers, drug treatment centers, and alcoholic treatment centers.

The American Medical Association believes that comprehensive health care should be available to the entire population, regardless of income, and to this end has endorsed H.R. 1818 (S. 218), the Comprehensive Health Care Insurance Act. It is a plan for full health care through private insurance, and a minimum requirement of federal funding to subsidize insurance premium for the poor. We are strongly opposed, however, to the enactment of a national health insurance program for one segment of the population as is contemplated in H.R. 1702.

Many of the provisions of H.R. 1702 are highly controversial and have been subjects of extensive national health insurance debates on concepts which are currently before the Congress, and on which no consensus has been reached.

A program of NHI dimension should not be adopted until Congressional review of the diverse NHI concepts and their ramifications has been completed. There is neither urgency nor need to warrant adoption of the extreme proposal presented by H.R. 1702 and we strongly urge its rejection.

A JOINT STATEMENT

OF THE

AMERICAN NURSES' ASSOCIATION
Division on Maternal and Child Health Nursing Practice

AND THE

AMERICAN ACADEMY OF PEDIATRICS

I. Introduction

The American Nurses' Association and American Academy of Pediatrics recognize collaborative efforts are essential to increase the quality, availability and accessibility of child health care in the U.S.A. In order to meet the health care needs of children, it is essential that the skills inherent in the nursing and medical professions be utilized more efficiently in the delivery of child health care.

Innovative methods are needed to utilize these professional skills more fully. One such innovative approach is the development of the Pediatric Nurse Associate* program. This program will enable nurses, both in practice and reentering practice, to update and expand their knowledge and skills. It is essential that physicians become more aware of the skills and abilities of the nursing profession and that such skills be expanded in the area of ambulatory child health to enable both the nurse and the physician to devote their efforts in the delivery of child health care to the areas of their respective professional expertise.

The expansion of the nurse's responsibilities would encompass some of the areas that have traditionally been performed by physicians. Proficiency and competence in performing these new technical skills associated with the expanded responsibility should be viewed as increasing the sources from which the nurse gathers data for making nursing assessment as a basis for diagnoses and action and thus contribute directly to comprehensive nursing. Nurses must therefore be prepared to accept responsibility and accountability for the performance of these acts and must have the opportunity to be engaged in independent as well as cooperative decision making.

The ANA and AAP are agreed in developing the following guidelines and concepts for short-term continuing education courses for Pediatric Nurse Associates (PNA).

II. Functions and Responsibilities

As nursing functions have changed over the years, and nurses have assumed responsibilities that have formerly been performed by physicians, the two professions have issued joint statements concerning the changes. The continuing discussions between the American Nurses' Association and the American Academy of Pediatrics concerning the preparation of nurses for pediatric nursing practice represents a formalized joint effort of both professions to collaborate and plan for the reorganization of certain health care services to children.

*The titles "Pediatric Nurse Associate" and "Pediatric Nurse Practitioner" are used interchangeably.

The following responsibilities in ambulatory child health care include those which are inherent in existing nursing practice:

1. Secure a health history.
2. Perform comprehensive pediatric appraisal including physical assessment and developmental evaluation on children from birth through adolescence.
3. Record findings of physical and developmental assessment in a systematic and accurate form.
4. Advise and counsel parents concerning problems related to child-rearing, growth and development.
5. Advise and counsel youth concerning mental and physical health.
6. Provide parents and other family members with the opportunity to increase their knowledge and skills necessary for maintenance or improvement of their families' health.
7. Cooperate with other professionals and agencies involved in providing services to a child or his family and when appropriate coordinate the health care given.
8. Identify resources available within the community to help children and their families, and guide parents in their use.
9. Identify and help in the management of techologic, economic and social influences affecting child health.
10. Plan and implement routine immunizations.
11. Prescribe selected medications according to standing orders.
12. Assess and manage common illness and accidents of children.
13. Work collaboratively with physicians and other members of the health team in planning to meet the health needs of pediatric patients.
14. Engage in role redefinition with other members of the health team.
15. Delegate appropriate health care tasks to non-professional personnel.

III. Continuing Education Programs

A. Goals

The goal of continuing education programs for preparation of Pediatric Nurse Practitioners is to provide knowledge, understanding and skill

that will enable them to assume a direct and responsible professional role in ambulatory child health care. The programs should build on previous nursing knowledge and skill and include some knowledge and skills that conventionally have been the province of the physician. Experimentation is indicated as the health professions attempt to change their functions.

On completion of the program, the Pediatric Nurse Associate should be able to:

1. Secure a child's health and developmental history from his or her parent and record findings in a systematic, accurate and succinct form.

2. Be able to evaluate a health history critically.

3. Perform a basic pediatric physical assessment using techniques of observation, inspection, auscultation, palpation and percussion and make use of such instruments as the otoscope and stethoscope.

4. Discriminate between normal and abnormal findings on the screening physical assessment and know when to refer the child to the physician for evaluation or supervision.

5. Discriminate between normal variations of child development and abnormal deviations by utilizing specific developmental screening tests and refer children with abnormal findings to the pediatrician.

6. Provide anticipatory guidance to parents around problems of child rearing, such as: feeding, developmental crises, common illnesses and accidents.

7. Recognize and manage specific minor common childhood conditions.

8. Carry out (and) or modify a pre-determined immunization plan.

9. Identify community health resources and guide parents in their use.

10. Make home visits in view of presenting health problems.

11. Make decisions arrived at prospectively and collaboratively with the physician in addition to decisions involving a level of traditional nursing judgments. Trust and a close state of inter-dependence are essential for this collaborative decision making.

B. Planning

Collaboration between nursing and medicine is vital in achieving understanding of the preparation of Pediatric Nurse Associates. In order to insure such collaboration, it is necessary that nursing and medicine assume equal responsibility for planning the Pediatric Nurse Associate

short-term continuing education programs.

Planning should take into account national, regional and local needs for ambulatory child health care. Planning should involve district and state nurses' associations, district or chapter chairmen of the AAP, and nursing and medical schools. Active participation should be sought from consumer groups, since their orientation to the changing roles of physicians and nurses will determine to a significant extent the effective utilization of these professionals.

C. Organization and Administration

Every attempt should be made to establish the educational programs to prepare Pediatric Nurse Practitioners under the aegis of accredited collegiate nursing programs. Whenever possible the program should be developed in collaboration with a Department of Pediatrics of a College of Medicine. Programs should conform to the existing policies and regulations governing the conduct of comparable, educational programs. As in the delivery of care, the organization and implementation of the educational program should be a joint Pediatric and Nursing effort. The educational programs should be financed as are other continuing education programs sponsored by the institution. A variety of funding sources may be included.

D. Services and Facilities

The program should provide:

1. A health service for evaluation and maintenance of mental and physical health of the students.

2. A counseling service for student guidance.

3. Library facilities which contain an adequate supply of books, periodicals, and other reference materials related to the curriculum.

4. Appropriate teaching aids and classroom facilities.

5. Clinical facilities for demonstration, student observation and directed practice experience in public and private ambulatory and applicable inpatient settings. These facilities should be in institutions, clinics or private offices which have sufficient qualified, experienced child care personnel, and adequate numbers of patients to provide the type and amount of experience for which the student is assigned.

E. Faculty

Collaboration between nursing and medicine is vital in achieving the goals of the program. For this reason, the planning and implementation of the curriculum should be a joint effort of both professional groups.

The medical and nursing co-directors of the program should be qualified through both academic preparation and experience as practitioners. The faculty should meet the same requirements as other faculty of the sponsoring institution.

Medical input will be primarily in those areas of health care that have traditionally been within the province of medicine. Since the acquisition of new knowledge and skills are intended to enhance professional nursing practice, appropriate nursing faculty should assume major responsibility for the development and implementation of the program.

It is envisioned that wherever appropriate, other members of the health team, for example, psychologists, nutritionists, and social workers, would participate in teaching so as to assist students in gaining perspective of the inter-dependent role and contributions of other health professionals. The nursing co-director of each program is also the logical person who should be responsible for the coordination of the educational input of these other health professionals.

Other instructional staff should be qualified through academic preparation and experience to teach the subject (or subjects) assigned.

The student-instructional staff ratio should be in at least the same proportion as similar education programs organized by the sponsoring institution.

Joint appointments for faculty between Departments of Pediatrics and Schools of Nursing are recommended.

F. Course Content

Curriculum should build on existing nursing knowledge and skills, updating and adding depth in the areas of normal growth and development, clinical pediatrics and the behavioral sciences. It should provide a systematic program to increase the nurse's ability to make a more discriminative and accurate assessment of the developing child.

GROWTH AND DEVELOPMENT -- A comprehensive review of growth and development and normal variations, including the use of the Denver Developmental Screening test or a comparable instrument.

INTERVIEWING AND COUNSELING -- Principles of the interviewing process, basic approaches to counseling parents in child rearing practices.

FAMILY DYNAMICS -- Study of attitudes and knowledge needed to identify factors that affect interaction between family members and critical periods in family life. Review of sociocultural patterns and their influence on family health.

POSITIVE HEALTH MAINTENANCE -- Basic child care, including physical assessment, nutrition, immunization programs, safety and accident prevention, dental health measures, and other aspects of anticipatory guidance.

CHILDHOOD ILLNESS -- Review of systems and the most commonly seen pediatric illnesses, with emphasis on prevention, management, early recognition of complications; and the more common emotional adjustment problems of each age group; importance of health education for families in providing better health care in the home.

COMMUNITY RESOURCES AND DELIVERY OF CHILD HEALTH CARE SERVICES -- Review of community resources, traditional modes of delivery of services and the referral process and new patterns of providing comprehensive health care.

FAMILY/NURSE/PHYSICIAN RELATIONSHIP -- Interpret goals of the nurse/physician team and role changes required for practicing in an expanded role. Review elements of working within a system while changing the system.

CLINICAL EXPERIENCE -- Planned field experiences and directed practice which provide a transition from theory to application should be incorporated into the program. These activities should allow for the application of previous and ongoing learning under the direction of competent instructors and practitioners. There should be qualified preceptors in each field of practice to which students are assigned under the general direction of the co-directors of the program.

C. Admission of Students

Only registered nurses are eligible for the programs. Policies for selection of students should be developed by the faculty of the sponsoring institution in cooperation with those responsible for conducting the programs. Admission criteria should be based on education and experiental factors, taking into account local needs and resources. Careful assessment of each applicant's qualifications is indicated, to assure that those admitted have a common core of knowledge and skill. If the applicant lacks preparation in an area regarded as essential, he or she should be guided to correct the deficit before entering the program, or to enroll in a supplemental course concurrent with enrollment in the Pediatric Nurse Associate program. Pre-testing for admission and appropriate placement appears advisable in the following areas: knowledge of growth and development of children, care of children with common health problems, child psychology, and family dynamics.

Because a larger purpose of this course is to change the current delivery practices of pediatric health care by placing in action working models of "pediatric team" care. it is recommended that the trainee already hold a job within a practice setting that serves as a source of comprehensive health care for all children in a family. It is recommended that each nurse accepted as a trainee be guaranteed by her employer the opportunity to function in an expanded role in the practice setting in which she works.

Adoption of this expanded role by the nurse makes it necessary for her to relinquish responsibility within her work setting for non-patient care tasks of an indirect and clerical nature. These tasks can be assumed by traided assistants, aides and secretaries.

H. Length of Program

Experience to date has indicated that a minimum of four months of educational experience is needed to attain the desired objectives.

The program should include a combination of classroom work, clinical practice and work experience composed of approximately four hours of class and eight to twelve hours of supervised clinical practice each week, with the remainder devoted to on-the-job work experience.

I. Evaluation

Special licensing or accrediting of programs or certification of individuals who complete the programs would be premature at this stage. Opportunity for experimentation in educational programs and in manpower utilization is essential for full exploration of ways to improve health services. The candidate who successfully completes the program should be provided with a certificate of completion, or other written statements, according to the policies of the educational institution under whose aegis the training was conducted.

It is imperative that the educational, attitudinal and economic aspects of the continuing educational programs for the Pediatric Nurse Associate be evaluated within each program. The data collected from ongoing evaluation can be utilized to modify and upgrade existing programs in the area of prerequisites, curriculum, facilities and faculty.

Each program should conduct ongoing evaluation of graduates to include:

1. Adequacy of care rendered.

2. Acceptance of expanded role by self, pediatrician and recipients of care.

3. Productivity measures and cost effectiveness analysis.

IV. General Information

Inquiries regarding school programs and careers for Pediatric Nurse Associates should be addressed to the Division on Maternal and Child Health Nursing, American Nurses' Association, 10 Columbus Circle, New York, New York 10019; or, Office of Allied Health Manpower, American Academy of Pediatrics, 1801 Hinman Avenue, Evanston, Illinois 60204.

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AMA Board of Directors concurred in the release January, 1971.

FHD/jl
1-29-71

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January 6, 1978

Honorable Paul G. Rogers
House of Representatives
Room 2415
Rayburn House Office Building
Washington, DC 20515

Dear Sir:

Thank you very much for the invitation to present testimony at your Subcommittee hearings in San Francisco on January 4 and 5 dealing with H.R. 1702. Unfortunately, the letter of invitation arrived while I was gone from my office and having returned only on January 3, it was impossible for me to be prepared to participate meaningfully.

I have reviewed the Maternal and Child Health Care Act and have several comments to offer. My first concern is that although health care for children and expectant mothers is certainly a vital part of our national health concern, it still remains only a part and I am concerned about partial solutions to larger problems. It seems to me that if this Act was enacted that it would tend to further fragment what is already a health care system that is characterized by numerous controls that do not necessarily create harmony within the system.

In light of recent considerations being given to some form of national health policy and perhaps some form of national health insurance program, it would seem to me that H.R. 1702 is premature. In that this Act establishes certain benefits and allowable fee schedules, I can imagine the turmoil that would ensue in the event that a national health program were established and the criteria for coverage were different. Of course, it could be said that the two programs could be coordinated but the very act of coordination would create additional conflict which really is, in my opinion, unnecessary, at this time.

Rather, I would prefer to see the Congress and interested, knowledgeable parties continue to seek ways to effectively implement a national health policy that very definitely addresses the need for appropriate health care for children and establishing proper health care habits for mothers but where these needs are part of a broader program that provides guidance for people of all ages and in all situations.

In conclusion, although the Bill seems to be well written and is reasonably comprehensive, I believe that this partial solution would

do more to hinder the overall objective on a national basis for good health care for all people than it would to implement effective health care in one segment of the population.

Once again, let me express my thanks for the invitation to participate.

Very truly yours,

Roswell M. Bond
Vice President - Marketing
President, Northwest Healthcare
ps 2/3

THE MEDICAL CARE FOUNDATION OF SACRAMENTO
AN ORGANIZATION OF THE SACRAMENTO COUNTY MEDICAL SOCIETY
650 UNIVERSITY AVENUE, SACRAMENTO, CALIFORNIA 95825 • (916) 929-1480

6 January 1978

Subcommittee on Health and the Environment
House of Representatives
Congress of the United States
Room 2415
Rayburn House Office Building
Washington, DC 20515

RE: H. R. 1702

Gentlemen:

This is a response to your request for comments from a medical care foundation with experience in open panel health care programs on the national health insurance Maternal and Child Health Care Act.

Certainly one of the most frequently abused portions of a commercial indemnity health insurance plan is the failure to include insurance benefits for professional services for the newborn and during the first years of life on a realistic basis and also the frequent exclusion of maternity benefits for many indemnity plans offered by employers. Obviously, this has led to the desire on the parts of some groups to mandate a national health insurance program which would include these benefits. A simple solution to this problem is simply to mandate a set of national health insurance minimum standards which would have to be included in any health service plan or indemnity plan offered by any carrier in the United States. These minimum standards during the first few years can emphasize pediatric care and obstetrical care as being a mandatory inclusion with a maximum co-payment or deductible feature. Obviously, this type of approach would obviate the need for placing special taxes on payrolls and wages. By setting simple national minimum standards, one could allow the current carriers and health plans to continue their present administration.

Another major problem we have with your plan is that relating to professional practitioner's services. It is not clear whether this plan makes every pediatrician and obstetrician an employee of the government, whether he can bill the patient for his services independently of what any national insurance plan such as yours will pay, whether he must accept assignment from the plan and whether he can balance bill for the differences between what the plan allows and what the current fee schedule in the community might call for. In setting a professional fee, who would represent the professional practitioners as far as the government is concerned? Would the fee schedule negotiated be binding on individual physicians without some legal agreement between the negotiator and the physician?

Some relatively minor comments would seem to me that the majority of mental health services provided to this population of patients, i.e., employees and their dependents are rendered not through mental health services in an organized fashion but rather through individual practitioners of psychiatric services. I do not feel that you should exclude the individual psychiatric professional from this program.

You will have to define major surgery in order to have a practical effect on the restriction of surgery to be performed by board eligible or certified surgeons.

We are happy to see that you plan to eliminate the restriction on prescriptions for less than ten days. This provision could very well end up costing more than it saves. If cost restraints are needed, some form of co-payment or annual deductible would avoid the potential problem of "charitable" abuse.

The development of grants to stimulate the formation of pediatric and obstetrical groups is laudatory. I believe the legal entity should be allowed to take various forms so that the individual pediatrician and obstetrician is not effectively eliminated as far as being a potential recipient of a grant.

In summary, we would say that health insurance to cover mothers and children would be a reasonable incremental approach as far as a national health insurance strategy is concerned. However, I do not feel that this should be administered by a government bureaucracy but rather should be included and mandated as a minimum standard for all private health insurance plans. Cost and quality control measures are being looked at in a great variety of programs including HMO, PSRO, HSAs and the like, and to write a separate set of standards for this program would seem to be redundant and certainly an example of government duplicity. These cost containment and quality control measures should be coordinated with your other agencies. We certainly do not agree with the financing mechanisms. It seems to me that by making maternity and pediatric care a minimum standard benefit, you would obviate the need for a special tax or governmental spending. We certainly believe that these bills, if modified properly, could provide a mechanism for the gradual expansion into a universal national health insurance program.

Special provisions for the uninsurable and those with marginal incomes and marginal employers may require special treatment or funding. However, we strongly feel that the main midsection of Americans that can afford their own insurance programs should be encouraged to do so. This bill provides for some new ways of providing health care. Freedom of choice and competition have been among the main strengths of the United States. It is especially important to retain them here in the complex systems and problems of health care financing and delivery.

Thank you for allowing us to review the material on this proposed piece of legislation.

Sincerely,

JAMES C. BRAHHAM, M.D.,
Past President and Trustee

JAMES J. SCHUBERT, M.D.,
Medical Director

L. ARNO LEJNIEKS, M.D.,
President

JCB:nf

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1/6/78

Honorable Paul G. Rogers, M.C.
Chairman, Subcommittee on Health and the Environment
Committee on Interstate and Foreign Commerce
House of Representatives
Washington, D.C. 20515

Dear Mr. Rogers:

I wish to thank you for your personal invitation to present testimony before your subcommittee on Health and the Environment pertaining to H.R. 1702, Maternal and Child Health Care Act. Unfortunately I was not able to present testimony because of commitments with the jury commission here in San Francisco and a heavy load with regard to scheduling admissions to the medical school. However, I know my colleagues from the University of California and others such as Dr. A. Bergman of the University of Washington have shared with your committee many of the concerns we have had here in trying to ensure an accountable system for the health of our children. The only footnote I would add to the committee record would be that I personally feel there is a total lack of indifference by the federal system to provide some collaborative models in working with health of children primarily in public and private schools. The majority of our nation's children attend schools either by compensatory law or by parental choice and there is no vehicle to provide the resources either through assessment and/or monitoring of the school health system nationally and/or locally. Most urban areas such as ours in San Francisco or Los Angeles public education have gone into deficit budgeting and usually the first cut is in the health care or health services field. I feel the federal government through your committee should certainly address the needs of better articulation and coordination using existing vehicles such as public educational systems to play an important role not only in reference to assessments and monitoring but in the critical area of prevention.

In closing I thank you again for the opportunity to address the committee. I hope that some time in the future the honor is extended to me or my colleagues again. With warmest regards and best wishes for the coming new year, I know your committee will continue to generate the critical questions and concerns facing the children of our nation.

Sincerely,

Dr. David J. Sanchez, Jr.
Associate Professor, Ambulatory and Community Medicine

DS/rm

[Whereupon the hearing was adjourned at 3 p.m., January 5, 1977.]

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