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ABSTRACT

These transcripts of hearings present testimony on how we can protect children in dangerous and violent environments. The statements address the longstanding efforts to reduce childhood injury in this country, with an emphasis on prevention as the best approach to child injury and health care. Statements and testimony are presented for the following: (1) Senators Dodd (Connecticut), Kennedy (Massachusetts), Thurmond (South Carolina); (2) Dr. C. Everett Koop, Chairman of the National Safe Kids Campaign; (3) four adolescents, victims of accidents or witnesses to violent crime, whose experiences highlight the benefits of prevention; (4) Senator Jeffords (Vermont); (5) the director of the National Center for Injury Protection and Control; (6) program director of the National Public Services Research Institute; and (7) an assistant professor of health policy. (AP)

S. HRG. 103-697

KEEPING OUR KIDS SAFE

HEARING

BEFORE THE

SUBCOMMITTEE ON
CHILDREN, FAMILY, DRUGS AND ALCOHOLISM

OF THE

COMMITTEE ON
LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

ONE HUNDRED THIRD CONGRESS

SECOND SESSION

ON

EXAMINING STATE AND LOCAL EFFORTS TO IDENTIFY AND PREVENT THE LEADING CAUSES OF INJURIES TO CHILDREN

MAY 10, 1994

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TUESDAY, MAY 10, 1994

KEEPING OUR KIDS SAFE

TUESDAY, MAY 10, 1994

U.S. SENATE,
SUBCOMMITTEE ON CHILDREN, FAMILY, DRUGS AND ALCOHOLISM, OF THE COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:00 a.m., in room SH-216, Hart Senate Office Building, Senator Christopher J. Dodd (chairman of the subcommittee) presiding.

Present; Senators Dodd and Jeffords.

OPENING STATEMENT OF SENATOR DODD

Senator DODD. The subcommittee will come to order.

Let me welcome everyone here this morning to the Senate Subcommittee on Children, Family, Drugs and Alcoholism. Our topic this morning is children and how we can keep them from getting hurt. Instead of just talking about children and kids this morning, we are going to talk with kids today, some of whom have gotten hurt and some of whom have narrowly avoided it.

Before going on any further, I also want to welcome a group of children from the Bank School in New York who are here in Washington as part of a mock Congress. Having given the commencement address at the Bank School last year for the students there, I am delighted they are here this morning as well.

I have become, as a member of the Senate, more increasingly concerned in recent years about the physical well-being of our Nation's children. For far too many of our youngest citizens, the formative years have become mine fields of risk. I will hold a hearing next week in this committee on the explosion of youth violence in our society and what we at the Federal level can do about that.

Too many children are being killed and injured due to violence in our country, and we will learn today that too many children are being killed and injured due to avoidable injuries, accidents that can be avoided through safety measures.

A number of young people will tell us in their own words why safety matters and what can happen to unprotected kids. In addition, we are going to hear from Dr. C. Everett Koop, the distinguished former Surgeon General of the United States, who is Chairman of the National Safe Kids Campaign, and from a panel of experts. I want to extend a very special welcome to Heather Giambo and Raymond Hurt from my own State of Connecticut. Heather will testify in a few minutes.

I will save a detailed discussion of the impact of preventable childhood injuries in our society for later in the hearing, but I will mention a handful of facts and statistics now that I think will illustrate the problem that we are discussing.

More children die annually from preventable injury than from all childhood diseases combined. Let me State that again because it is a startling statistic. More children in our country die every year from preventable injuries than from all childhood diseases combined.

Each year, more than 8,000 children under the age of 14 are killed as a result of preventable injuries, and 50,000 are permanently disabled.

Each year, these injuries cause 360,000 hospitalizations and more than 10 million trips to emergency rooms across our land.

The injuries happen in a variety of ways, from traffic accidents to burns, from drowning to poisoning, from choking to falls. The list goes on.

This year, 1 out of every 4 young Americans will suffer a preventable injury serious enough to require medical attention. That is 13 million a year.

We are highlighting these statistics now because this is Safe Kids Week. All across this country, communities are thinking about child safety. They are organizing bicycle rodeos and demonstrating child safety seats. They are installing smoke detectors and leading drowning prevention clinics. They are teaching each other the simple steps, the very simple steps they can take to safeguard young lives.

The diving force behind all of these events is the knowledge that these injuries are not random. They do not just happen. They are not just accidents. Part of what we want to accomplish today is to publicize the fact that there are a series of clearly defined and relatively painless steps parents and adults can take to protect their children from these injuries and death. Purchasing bike helmets, child safety seats and seat belts, smoke detectors, with batteries in them that work, and inserting fencing around swimming pools are some of the things, the very simple things that can be done to save thousands of lives.

We are also going to examine what we can do at the Federal level to support these efforts. Despite the grave threat to children's health that unintentional injuries represent, injury research receives only 2 cents out of every Federal health research dollar. That is far too little.

I hope as we begin the markup of the national health legislation that this particular area will receive the proper attention it deserves. A great deal of discussion has been ongoing about trying to reduce the costs of health care in our society. I cannot think of anything that would reduce costs more quickly than to stop the problems from occurring in the first place. And so it is going to be a major concern of mine as we begin in this very committee, the full Committee of Labor and Human Resources, to try and raise the awareness about preventable injuries and see to it that we get the kind of support and backing as part of any national health care legislation that preventable injuries and safe children deserve.

I will now put my prepared statement and that along with Senators Kennedy and Thurmond in the record at this point.

[The prepared statements of Senators Dodd, Kennedy, and Thurmond follow:]

PREPARED STATEMENT OF SENATOR DODD

I would like to welcome all of you here today to this hearing of the Senate Subcommittee on Children, Family, Drugs and Alcoholism. Our topic is kids and how we keep them from getting hurt. Instead of just talking about kids, we will talk with kids today, some of whom have gotten hurt and some of whom have narrowly avoided it.

I have become increasingly concerned in recent years about the physical well-being of our Nation's children. For far too many of our youngest citizens, the formative years have become mine fields of risk. I will hold a hearing next week on the explosion of youth violence and what we at the Federal level can do about it.

Too many children are being killed and injured due to violence, and, as we will learn today, too many children are being killed and injured due to accidents, accidents that can often be avoided through safety measures.

A number of young people will tell us in their own words why safety matters and what can happen to unprotected kids. In addition, we'll hear from Dr. C. Everett Koop, the distinguished former Surgeon General who is chairman of the National Safe Kids Campaign, and from a panel of experts. I want to extend a special welcome to Heather Giambo and Raymond Hurt. From my own State of Connecticut. Heather Giambo will testify in a few minutes.

I will save a detailed discussion of the impact of preventable childhood injuries on our society for later in the hearing, but I will mention a handful of facts and statistics now that I think will illustrate the problem we are discussing:

—More children die annually from preventable injury than from all childhood diseases combined.

—Each year, more than 8,000 children 14 and under are killed and 50,000 permanently disabled.

—Each year, these injuries cause 360,000 hospitalizations and more than 10 million trips to the emergency room.

—The injuries happen in a variety of ways, from traffic accidents to burns, from drowning to poisoning, from choking to falls.

—This year, one out of every four children will suffer a preventable injury serious enough to require medical attention. That is 13 million a year.

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death—purchasing bike helmets, child safety seats and seat belts, smoke detectors, and inserting fencing around swimming pools.

We will also examine what we can do at the Federal level to support these efforts. Despite the grave threat to children's health that unintentional injuries represents, injury research receives only two cents out of every Federal health research dollar.

It is time for us to take a serious look at the tragedy of preventable childhood injuries, and I look forward to discussing it in depth today.

PREPARED STATEMENT OF SENATOR KENNEDY

Today's hearing on preventable injuries is an important step toward creating safer homes and neighborhoods for children. Their children's safety should be a top priority. Each year, nearly 8,000 children die from injuries that could be prevented. Thousands more must live with permanent disabilities. Unintentional injuries are the leading cause of death for children under 14, and result in more deaths than all childhood diseases combined.

Under the strong leadership of Dr. C. Everett Koop, the National Safe Kids Campaign is bringing this issue to the forefront. Their work has already had a significant impact by reaching out to parents with safety messages on how to protect their children from preventable injuries. This week is National Safe Kids Week—a tribute to their tireless efforts to bring child safety into every American home.

Investing in prevention makes sense, in both human and economic terms. In 1988, the lifetime cost of unintentional injuries to children under 14 was $13.8 billion. The human costs are far higher, because so many tragedies could have been prevented. Ninety percent of unintentional injuries could be avoided with simple interventions.

Prevention is highly cost-effective. Every dollar invested in bicycle helmets saves $30. Every dollar spent in child safety seats saves $32. Every dollar invested in a poison control center saves $7.50. These savings add up, and small investments today will yield large returns in the safety of children tomorrow.

We must use more opportunities to help parents identify potential safety risks for their children, and show them how to eliminate their risks. Many dangerous situations can be averted through simple measures. A smoke alarm, a bicycle helmet, or a window guard can mak all the difference.

I look forward to working with the National Safe Kids Campaign and the National Center for Injury Prevention and Control at the Centers for Disease Control to make homes and neighborhoods safer places for children. Let us heed of the voices of children like Adam Casavant and Michelle Pratt from Massachusetts, who remind us how easy—and how important—it is to provide basic safety precautions for children.

PREPARED STATEMENT OF SENATOR THURMOND

Mr. Chairman, it is a pleasure to be here today to receive testimony concerning child safety. I would like to join you and the rest of this subcommittee in welcoming our witnesses here today. I

would especially like to welcome Mr. Jason Gregory and Miss Misty Kimsey from my home State of South Carolina. (ask that they and their families be recognized) I would also like to welcome former Surgeon General, Dr. C. Everett Koop.

As you may know, Mr. Gregory is 11 years old and is from Spartanburg, SC. He was critically injured in a motorbike accident. Fortunately, he was wearing a safety helmet, and his doctors believe that saved his life.

Miss Kimsey is also 11 years old and is from Blacksburg, SC. Because of a fire prevention program at her school, she encouraged her parents to buy a fire detector. The very night they installed the detector, their house was consumed by fire. Fortunately, the alarm alerted them to the fire and the family escaped unharmed.

Jason and Misty's experiences illustrate, first hand, the importance of injury prevention programs and safety awareness.

Again, I would like to welcome all of our witnesses here this morning. I look forward to their testimony.

So with that, let me welcome our first panel, and particularly our first witness, Dr. Koop, who served this Nation with great distinction as our Surgeon General, has been involved with children's issues for virtually his entire adult life, having worked, of course, with the Children's Hospital in Philadelphia from 1948 until he left his service there to be the Surgeon General of the United States. He serves on a variety of boards and has been a champion of so many issues involving young people.

Dr. Koop, I know that you are very familiar with the curing process, probably more familiar than you would have cared to have been during your tenure as Surgeon General. And, given the fact that you testified on so many occasions you are probably having a flood of deja-vu experiences, I must say—and I want particularly to point this out—you always testified with great effect, with great effect. I have great respect for the present occupant of that office and those who have held the job over the years, but I do not think I am exaggerating when I say that when people say the words "Surgeon General" today, the one name that comes to mind very quickly is yours, for the tremendous work that you did for our country in highlighting and raising the level of awareness for various public health issues. The bully pulpit of that position did an awful lot to help people in this country, so we are particularly honored that you are here this morning. We welcome you back, back to this committee, and we look forward to your testimony this morning.

STATEMENTS OF DR. C. EVERETT KOOP, CHAIRMAN, NATIONAL SAFE KIDS CAMPAIGN, WASHINGTON, DC; HEATHER GIAMBO, GREENWICH, CT; MARCUS YOUNG, KANSAS CITY, MO; JENA GROSSER, ELKHART, IN; ZACHARY NUSE, JOHNSON, VT; AND TONIA ORTIZ, WASHINGTON, DC

Dr. KOOP. Thank you very much, sir. First, I would like to commend you on your longstanding efforts to reduce childhood injury. Five years ago, you chaired a landmark hearing on injury prevention, and today you once again are focusing on this issue as in America grapple with health care reform. So I thank you.

I come before you today to speak of unintentional injury to children—the futility of it, the heartbreak of it, and the cost of it. Unintentional injury is still a number one killer of children nationwide. Nearly 8,000 children die each year, and it claims more lives than all of the childhood diseases put together. And during the time it takes to hold this hearing, 1 child will die and 9 children will become permanently disabled as the result of an unintentional injury.

There are charts here that describe some of the things I will be saying, but 13 million children receive medical treatment each year for unintentional injury. That is 1 in 4, Mr. Chairman, and the cost is a staggering $13.8 billion.

In 1989, I came before your subcommittee to relay the same message that our kids and the experts behind me will convey to you today; that is, that good preventive measures save families untold suffering. However, now in 1994 we have an additional message, and that is that injury prevention will also save our health care system billions of dollars, and all of us in the health policy community are searching for ways to make care optimal that can be delivered cost-effectively.

I speak today as a long-time pediatric surgeon. For 35 years I was on the front line of injury for kids when I was surgeon in chief of the Children's Hospital of Philadelphia, and there I saw thousands wheeled through our emergency room, the victim of crashes with traffic, pedestrian injuries, fires, scalds, bike crashes, near drownings, and poisonings. Helping many of these children was my life's work and, therefore, enormously satisfying, but, in addition, painfully frustrating, too, because many of these injuries could have been avoided. I can tell you there is nothing more difficult than telling the agonizing parents that the death or permanent disability of a child just did not have to happen. Today, with such devices as safety belts, child safety seats, bicycle helmets and smoke detectors, 90 percent of all unintentional injuries can be prevented.

I suppose you and the country know me best for my high-profile directives as Surgeon General in regard to smoking and AIDS. But I think some of the work of which I am most proud were my efforts to help build grass-roots movements. In the area of childhood safety, I knew that families and kids themselves had to hear more about the need for wearing safety belts and bike helmets and so on and the vital importance of having smoke detectors that work, as well as parental supervision of small children when they are around tubs or pools. I knew that this message had to come from the community itself to be effective.

In 1986, I was, therefore, pleased to accept the chairmanship of the National Safe Kids Campaign, which today is still the only organization solely dedicated to the prevention of unintentional injury in kids.

Mr. Chairman, when I testified here 5 years ago, there were 40 Safe Kids Coalitions. Today there are 164 in nearly every State, and these are thousands of committed volunteers and professionals who have helped to pass the first bike helmet laws in their States, smoke detector ordinances, and close loopholes in passenger safety laws.

The National Safe Kids Campaign was born in 1987, and since that time there has been a tremendous documented decrease in certain injuries. We are especially proud of our work in the area of bicycle helmet legislation, and in the past 7 years, we have seen local and State coalition pass bike helmet legislation in many States.

Since the implementation of bike helmet and bike safety awareness strategies, the helmet use among children has increased from 1 percent to 15 percent, but there are three other very successful programs: one in scald and burn prevention, residential fire safety, and Safe Kids Buckle Up, a child occupant protection program. But there is still much to be done, and this hearing is part of that process.

I a joined today by others who will testify. The adults will speak on situations where qualified by their credentials, and the four younger participants have arrived at this hearing by way of circumstance. Each one has had his or her life changed forever by a childhood injury. Each one has come face to face with life-threatening injury, and their grave experiences support our health reform proposals in a way far more compelling than scientific studies.

On' 4 of our youngsters will testify today, but they are not alone. In Washington this week, there are 102 kids who are survivors and heroes of injuries, and I know all of us wish that none of these had ever happened. But these kids know the trauma of the emergency room, weeks in the hospital, months of rehab, and many chaperons who are here today are the parents who remember the worries they had, not only for their child's health but the family's budget. They are the National Safe Kids Summit participants, and right now they are behind me here. Maybe you youngsters would put your hands up so people can see who you are.

[A show of hands.]

Senator DODD. Terrific. Welcome.

Dr. KOOP. Mr. Chairman, dollars spent on unintentional injury prevention result in millions of dollars in medical cost savings. In health care reform, we must improve the level of care, but also find ways to cut staggering health costs.

I would like to submit to you, sir, for the record the National Safe Kids Campaign Health Reform Policy Report. It cites the very simple, low-cost devices that really work in saving lives and money.

For instance, bicycle helmets such as this. As two children here today will testify, bike helmets like this one can save hundreds of lives, as well as prevent very serious long-term brain injury that can result from a bike fall. As one parents said, if only parents could know that when they send a kid out on the streets without a helmet, he or she could return and never be quite the same child again.

There's a safety seat sitting over there on the lectern, and child safety seats could save an additional 500 lives every year if they were used correctly for all young children. These seats saved 180 lives and prevented 70,000 injuries last year. However, only 25 percent of low-income parents use them, while 75 percent of other children are restrained. Precious infants should not be held and considered safe in the arms of their parents in a moving vehicle.

Another thing that can save lives is a smoke detector. Ninety percent of all children who die in fires lived in homes without working smoke detectors, and 16 of the children behind me today have survived fires and know the importance of working smoke detectors. We will hear from one of them here in a few minutes.

I think, Mr. Chairman, that the Federal Government has an excellent opportunity now to lead the way by putting prevention up front where it belongs in health care reform. We know that there is no better health care investment than in childhood injury prevention. Here are our recommendations:

First, that every child should have access to a broad range of injury prevention services. For instance, the Federal Government should provide subsidies to low-income families to assure their use of child safety belts, bike helmets, and smoke detectors.

Second, the Federal Government should provide incentive grants to those States which are saving lives and dollars by having strong laws related to traffic safety and safety belts, and all of the other things that I have mentioned. Michigan's child safety law, for example, has already shown a 25 percent reduction in injury, and New Jersey's bike helmet law reduced deaths by 80 percent and injuries by 40 percent just in the first year of its application.

Third, grants to fund training for primary care physicians to do more injury prevention counseling. Primary care doctors can do much more than they do to counsel children and their families, but they have to know how to do it.

Finally, the Federal Government also should expand grants to community health centers to include injury prevention services.

Also, childhood injury prevention is a State responsibility, and we will continue to urge States to pass legislation and strengthen enforcement of those laws already on the books.

There are still nine States, for example, with no mandatory smoke detector laws, and still 1,200 kids die every year in residential fires and over 11,000 are injured.

In traffic safety, all but two States have passed safety belt laws, but many of the States have major loopholes in their child occupant protection laws.

Ten States have passed mandatory bike helmet laws.

Finally, I see injury prevention as a community responsibility as well. We all have a role to play in keeping children safe. The National Safe Kids Campaign recommends that businesses, physicians, nurses, insurers, parents, and other members of the community work together toward national efforts to curb childhood injury.

The National Safe Kids Campaign believes that immediate legislative action is needed by this administration to make sure that our kids are all "safe kids."

I think now it is time for you to turn your attention to these young people, Senator Dodd, and thank you very much again for having this hearing.

Senator DODD. Thank you very, very much, Doctor. I appreciate particularly your four suggestions. [Applause.]

Senator DODD. We do not normally tolerate applause at hearings, but this is very appropriate. We thank you.

[The prepared statement of Dr. Koop appears at the end of the hearing record.]

Senator DODD. Let me first of all thank our next panel of witnesses here, these young people, for being here. I want to tell you how very honored we are that you are willing to take some time and testify. You are representing, of course, the other young people in this room and across the country.

Dr. Koop asked you to raise your hands. Why don't we get everybody here who is representing another State as part of this campaign, all the other—I guess it would be about 95—to stand up? Where are you here? Stand up, those children who are here today, so we can all see you and thank you for being here.

That is terrific. I want everybody to see them. Now, that deserves applause, too. [Applause.]

Senator DODD. Thank you very, very much.

Normally in hearings we listen to the experts and the people who bring a lot of knowledge to a particular issue, and that is extremely valuable in the conduct of any important hearing. But I thought it would be worthwhile this morning that we also listen to children who are the ones who are affected, who can talk very clearly, very directly about what has happened, either where their lives were saved or protected because they used the various things that Dr. Koop has already talked about, or where they suffered because they did not use them. I thought it would be a strong piece of evidence to offer to my colleagues opportunity to meet with some of you today, and for the purposes of this hearing to listen to representatives of these young people talk about their own experiences.

I am very pleased to welcome our first witness. You are not going to be shocked in the audience to find out that the first witness is from Connecticut today. Heather Giambo is 11 years old, and she is from Greenwich, CT. She had a fall from a bicycle. But because she was wearing a helmet, she was not seriously injured. We thank you for coming here today, Heather. We appreciate it very much.

Marcus Young, who is next to Heather, is a 14-year-old from Kansas City, MO, and he was riding a bicycle without helmet. He is going to tell us about his experiences.

Jena Grosser, who is sitting next to Dr. Koop, is 11 years old, and she is from Elkhart, IN. I have been through Elkhart, IN. I know where that is. She was able to save her 5-year-old brother, who has cerebral palsy, when he fell into a pool.

Our next witness is Zachary Nuse. Zachary is 12 years old, and he is from Johnson, VT. He and his family were saved by having a working smoke detector. The word "batteries" is pretty important to keep in mind, isn't it, Zachary? You are going to tell us a bit about that.

Last, we want to welcome Tonia Ortiz. She is 16 years old, and she is from right here in town, Washington, DC. She has witnessed several violent incidents. At the age of 14, she witnessed a shooting, and the Latin American Youth Center has started a therapy support group for young women based on Tonia's experiences. We are delighted that you are here this morning as well.

So back to you, Heather. We will begin. Share with us your statement, and then we will just go to each one of you right down the line and have you share your thoughts with us.

Heather, why don't you pull that microphone close to you so we can hear you. You want to maybe move that water glass so it does not spill. Then you have to speak right into that microphone. We will hand it down so each person can speak.

Ms. GIAMBO. My name is Heather Giambo. I am 11 years old, and I live in Greenwich, CT. I am here today to tell you how a bicycle helmet saved me from serious injury. I am glad a Senator from my State, Senator Dodd, cared enough about keeping kids safe to hold this hearing. Thank you, Senator Dodd.

Last summer I was on vacation in Oregon with my family. We were visiting my grandparents and my aunt. I was riding a bicycle on a bike trail, when I turned around, lost control of the bike, and wiped out. I hit my head on the ground, broke my arm, and ended up getting a cast. It really blew the rest of the summer.

But it could have been much worse if I had not been wearing this bicycle helmet. See these scratches? See this dent? This could have been my head. It really made me realize a helmet protects your head and brain in a crash.

A lot of kids die every year because they did not wear bike helmets. Maybe they did not have one, or maybe they had a helmet but did not like to wear it. A lot of kids do not like to wear them. They do not think the helmets are cool, or they think they get in the way.

I do not really like to wear mine either, but I know that if you do not wear your helmet just one time, that might be the time you crash your bike. You just never know.

I would like to thank my Aunt Kathy because she bought me this helmet, and one for my sister. We already have our own helmets back at our house in Connecticut, but my aunt wanted to make sure that my sister and I had helmets to wear in Oregon, just so we could be safe.

My aunt is a teacher, and she bought the helmets at her school, where they were selling them at a reduced price. A boy in her town was killed in a bicycle crash. He was not wearing a helmet. After that, the whole town got involved in bicycle safety, and part of that was holding bike helmet sales. I think this is a good idea because more parents might buy helmets if they do not cost very much.

In Connecticut, where I live, there is a law that says all kids under the age of 12 must wear a helmet. In Oregon, where I had my bike crash, there is also a law that says anyone under 16 must wear a helmet while riding a bike. A lot of kids do not pay attention to the laws because they think they are not really enforced. I do not think there are enough police watching out for children who are not wearing helmets. They should enforce the laws more because it can save a kid's life.

Everyone should care about kids wearing bicycle helmets. Towns and schools should teach kids about safe riding, and there should be programs where everyone can afford to buy a bicycle helmet or get one for free. and bicycle helmet laws show that the Government cares about kids and families.

My broken arm is better now, and I am riding a bicycle again. I do not think about the crash much anymore, but I keep my helmet to remind me of what can happen if you do not wear one. I hope it reminds you, too.

Thank you.

Senator DODD. Thank you very much, Heather. Well done. [Applause.]

Senator DODD. Marcus, thank you for being here.

Mr. YOUNG. My name is Marcus Young. I am 14 years old, and I live in Kansas City, MO.

It was interesting for me to hear Heather's story. I am sorry she broke her arm. But the bike helmet saved her from more serious injuries.

A bike helmet could have helped me, too, but the problem is I was not wearing one. I never thought anything bad could happen to me, but that changed on August 23, 1993. The last thing I remember on that day was riding my friend's bike back from the candy store. I was riding down a hill of a one-way street, when I saw a car headed for me. It was too late to avoid the car, so I put my arm like this.

I was not wearing a bike helmet, so when I hit my head on the ground, on the concrete, I really damaged my head. The doctors say I had a traumatic head injury and a mini-stroke. I have a scar on the back of my head, but my hair has grown back now so you cannot see it as much anymore.

I really thank God and all the doctors, nurses, and therapists and everyone else at Children's Mercy Hospital. They saved my life.

My life is different now because of the bike crash. I still walk with a limp a little bit. There is some poor function in my left arm, and some of my fine motor skills are not as good as they used to be. I used to play football on a team. I cannot do that for a while. I missed the whole first quarter of school. I have not been on a bicycle since then. I really do not feel like I ever want to ride a bicycle again.

After I was in the hospital, I went to rehab. I still go for physical therapy. My mother has worked with me a lot. She always encourages me and tells me to keep at it. I do these exercises most of the time. It helps me with my motor skills, like this.

Senator DODD. Those are your fingers you are showing us. You touch your thumb to each finger?

Mr. YOUNG. Yes.

Senator DODD. And that helps you. You have to keep doing it. Your mother is right. You keep doing that, okay? Dr. Koop will tell you that, too.

Mr. YOUNG. I never wanted to wear a bike helmet. I did not think they were cool. A lot of kids feel that way. My idea is that kids could put stickers of sports teams on their helmets. If their helmet said "Chiefs" or "Bulls" or "Rams," they would think their helmets are cool.

When I was in the hospital, I was hooked up to a lot of machines. I know now that this cost a lot of money. I know that doctors and hospitals and ambulances all cost a lot of money. A whole lot more than a bicycle helmet. If I had worn my bicycle helmet that day, I could have saved my head and saved a lot of money.

I also was not thinking much about safety that day. I should not have been riding in the middle of the street down a hill. I tell other kids that they should be careful where they ride a bicycle. And I

definitely tell them to wear a helmet when they ride. I say that if they do not wear a bicycle helmet, they are living dangerously.

I had a bad experience, but I am doing something good with it. Last week I spoke before the City Council in Kansas City, and later this month I am going to Missouri State capital and Washington State capital to testify in favor of bike helmet laws for my State and other States.

I think there should be bike helmet laws everywhere in the country. I hope my story will mean other kids will not have to go through what I went through.

Thank you.

Senator DODD. Thank you, Marcus, very, very much. We are very proud of you. [Applause.]

Senator DODD. What is it, Marcus? Do you want to say something else, Marcus? Oh, I thought you were going to say something else.

Well, you did a great job. We are very proud of you.

Mr. YOUNG. Thank you.

Senator DODD. Thank you.

[The prepared statement of Mr. Young follows:]

PREPARED STATEMENT OF MARCUS YOUNG

My name is Marcus Young. I am 14 years old and I live in Kansas City, MO.

I never thought anything bad could happen to me. But that changed on August 23, 1993. The last thing I remember on that day was riding my friend's bike back from the candy store. I was flying down a hill a one-way street, when I saw a car headed right for me. It was too late to avoid the car, so I put up my left arm like this.

And after that, I don't remember anything. I was taken to Children's Mercy Hospital and I was unconscious for four days. When I woke up, I couldn't even remember my name. I didn't remember what happened, but I was told that I hit the car's windshield and landed on the street, hitting my head on the concrete. It took the Neurosurgeons six hours to get the glass out of my arm and repair the damage. Here are my scars.

I wasn't wearing a bike helmet, so when I hit my head on the concrete, I really hurt it. The doctors say I had a traumatic head injury and a mini-stroke. I have a scar on the back of my head, but my hair has grown back now, so you can't see it as much anymore.

My life is different now because of that bike crash. I still limp a little bit, there is some paralysis in my left arm, and some of my fine motor skills are not as good as they used to be. I used to play on a football team. I can't do that again for awhile. I missed the whole first quarter of school. I haven't been on a bicycle since then, and you know, I really don't feel like I ever want to ride a bicycle ever again.

After I was in the hospital, I went to rehab. I still go for physical therapy. My mother has worked with me a lot, she always encourages me and tells me to keep at it. I do these exercises all the time. It helps with my motor skills.

I never wanted to wear a bicycle helmet. I didn't think they were cool—a lot of kids feel that way. My idea is that kids could put stickers of sports teams on their helmets. If they're helmet said "Chiefs" or "Bulls" or "Rams" they would think their helmets are cool.

When I was in the hospital, I was hooked up to a lot of machines. I know that this cost a lot of money. I know that doctors and hospitals and ambulances all cost a lot of money—a whole lot more than a bicycle helmet. If I had worn a bicycle helmet that day, I could have saved my head, and saved a lot of money. I also wasn't thinking much about safety that day. I shouldn't have been riding in the middle of the street—flying down a hill. I tell other kids that they should be careful where they ride a bicycle. And definitely tell them to wear a helmet when they ride. I say that if they don't wear a bicycle helmet, they're living dangerously.

want all the lawmakers to listen to my story. There should be bike helmet laws everywhere in the country. Right now, there is no bicycle helmet law in Missouri.

Senator DODD. Jena, thank you for coming. We appreciate your being here as well. Why don't you tell us your story?

Ms. GROSSER. My name is Jena Grosser. I am 11 years old, and I live in Elkhart, IN.

I am glad this committee is giving kids a chance to tell their stories because it is very important for everyone to understand that injuries and deaths can be prevented. I am very happy to see that my Senator, Dan Coats, is on this committee.

Senator DODD. He wanted to be here this morning, by the way. He is at another hearing, and he is going to try and get over here. But he wanted me to tell you specifically that he will try and get by, and he is glad you are here.

Ms. GROSSER. Last summer, I helped to prevent my brother from drowning. It all happened in a flash. I did not even have time to think. I just had to jump in and try to save him.

My family was on vacation at a campground in Wyoming. We were all at the pool. My sister was in the pool, and my little brother, Jared, who was 5 at the time, was sitting at the edge of the pool. I was standing near the pool, and so were my parents. My father went to get something, and he called to my mother to ask a question. She stepped away for a second to help him. Jared saw a ball in the water, and he reached for it. Then he fell in. Jared cannot swim, and he has cerebral palsy. It all happened so fast. I screamed for help, jumped in the pool, and held him up while I treaded water. I knew I was not strong enough to pull him out of the pool, so I thought to myself, "You better just try to keep his head out of the water until somebody comes." My mother came running and pulled Jared out of the pool. He was okay.

My parents were very proud of me, and now Jared calls me his "hero" all the time. When I first got out of the pool, I did not think too much about what I had done. But then later I thought about what could have happened if I didn't jump in to help Jared. I know that it only takes a minute or so for a child to drown, so it is a good thing that I was right there and that I am a good swimmer.

I took swimming lessons, and I think it is important for all kids to learn how to swim and to learn the safety rules when you are around the water. I just took a CPR class, and I really liked it. I think you are never too young to learn CPR, but you must know how to use it correctly. CPR is not something to play around with.

My mother is a member of the Elkhart County Safe Kids Coalition in my home town, and safety has always been important in my family. What happened to us shows that a drowning or near drowning can happen anytime. In our case, it happened at a swimming pool, but I know that kids can drown in bathtubs and buckets, too. Kids can drown in just a couple of inches of water. Every year 1,200 children under the age of 14 drown; more than half of those kids are under 5.

It is amazing that water is the number one killer of kids under 5. People say it was lucky that I was there to help my brother, but it was not luck that taught me how to swim and to know about safety. I learned that in swim class. All kids should take swimming lessons so they learn the right way. I think that swimming classes should be mandatory in all schools because not only do you learn how to swim, you also learn about safety and you learn to think

quickly. I am in the 5th grade, but even kids younger than me should learn.

Since the incident and since my mother is a member of Safe Kids, we have talked a lot about pool safety. I also learned that all pools should have four-sided fences around them. Sometimes kids get into the pools because they enter the pool area right from the house.

Since this happened, my little brother always wears a life jacket when he is near the water, even when he is wading in the pool in the backyard. I learned that injuries can happen in a flash, so it is a good thing to be prepared like I was.

Thank you.

Senator DODD. Thank you, Jena, very, very much. [Applause.]

Zachary, before you begin, I want to introduce my colleague and friend from Vermont, Senator Jeffords, who has been a tremendous supporter and backer of so many different efforts, not the least of which is this particular issue. And since you are from Vermont, Senator Jeffords wanted to say a few words. So let me recognize my colleague.

OPENING STATEMENT OF SENATOR JEFFORDS

Senator JEFFORDS. Thank you very much, Mr. Chairman. I want to thank you for these hearings, and also you, Dr. Koop, for your leadership not only here but in many other areas.

Zachary is a fine young man. He is a high blue belt in Tae Kwon Do, and he is going to tell us about the need for all of us to be very careful that we have smoke detectors in our homes. Ninety percent of the young people that die in fires in this country each year are in homes that do not have any. So I think we can learn a good lessons from Zachary's testimony.

[The prepared statement of Senator Jeffords follows:]

PREPARED STATEMENT OF SENATOR JEFFORDS

Thank you, Mr. Chairman, for holding this hearing. The safety of our children is extraordinarily important to the overall health of our society. Rarely do we have an opportunity to prevent health care costs and human suffering as directly as we can with prevention of accidental injury of our young people. The SAFE KIDS organization is truly providing a public service in two ways; teaching how to prevent injury from occurring while also raising public awareness of these problems and their cost to society.

The stories we will hear today are terrifying, and we are very lucky to have our narrators here to tell them. Every year we lose nearly 8,000 kids in fatal incidents which might have been averted, while another 50,000 children are permanently disabled. Even one child is one too many if we can do simple things to keep our next generation safe.

We will hear from Zack Nuse, from my home State, whose life and whose family's lives may well have been saved by the one smoke detector in their house. We can not ask for a better return on an investment than that of many lives for one small appliance. Ninety percent of the kids killed in fires each year lived in homes without working smoke detectors.

As someone who is in the process of patching up my home, you can be sure that after hearing Zack's story today that I'll be extra sure to have smoke detectors located on each level of my home. As responsible adults we need to listen to these children's stories and learn from their experience.

Thank you Mr. Chairman.

Go right ahead, Zack. Good to have you here.

Mr. NUSE. My name is Zachary Nuse, but everyone calls me Zack. I am 12 years old, and I live in Johnson, VT. I am very glad that my Senator, James Jeffords, is on the committee and is here today to listen to my story. In a minute, I will tell you about the scariest night of my life, but first I want to say that I feel lucky to have a chance to be in Washington to attend the Safe Kids Summit and to meet other kids from all over the country who are like me.

It was almost exactly a year ago, May 8th. My brother, two sisters, and I were sleeping. A fire started in the basement where some mattresses were stored and were placed too close to the water heater. The smoke had already reached the main floor before my Dad heard the smoke detector. That is because we only had one smoke detector in the house, near my bedroom. My Dad and my Stepmother Ingrid got everyone out of the house through the front door. The smoke was everywhere. The fire fighters said if it had been a few minutes later, we would have had to escape out of the bedroom windows. My baby sister, Liana, was the only one hurt. She had some blisters from the heat. She was only 6 months old then. She is okay now. Even though we were scared, Ingrid says we were really calm and we handled the situation very well. She says that is because of all our training in martial arts and that we have good concentration. I have a high blue belt in Tae Kwon Do.

The house had a lot of damage, but the important thing is that four kids, two adults, and a dog and a cat all escaped, and we are all okay thanks to the working smoke detector.

We rebuilt the house, and we made sure this time our house is a safe house. We installed smoke detectors on every floor and two in the basement. If we had a smoke detector in the basement before the fire, we would have heard it and maybe the fire would not have spread as far as it did. It cost a lot of money to rebuild the house, a lot more than a couple of smoke detectors cost. We also built an escape ladder out of my sister's bedroom window so that if we have another fire, we definitely have an escape route from the top floor. But I hope we never have another fire again.

My Dad and Ingrid say they wish they had been more careful about storing the mattresses. You always hear about how fires start, and it seems like they all could have been prevented. I think it is important that kids and families learn how they can protect their homes against fires. It is something that can be done through schools, at work, and throughout the community.

There should be strong smoke detector laws everywhere to make people put a smoke detector on every floor and in every bedroom. My home State of Vermont has a smoke detector law, but it only applies to new homes. Smoke detectors do not cost very much, only about $10 apiece. And for families who cannot afford them, it

seems like any city would rather spend a few dollars on a smoke detector than watch its houses burn down.

You have heard from Heather and Marcus, who told you about being injured, and Jena, who told the story about saving her brother. We are different types of kids with different stories to tell, but we have a lot in common. We all know how important it is to prevent injuries, and we know it because we have been there.

We hope other kids never have to go through what we have gone through. It would really help if Congress would make more laws to keep kids safe, and when it comes time to spend our money, we hope you remember our stories and spend money on programs that will teach people about safety and help people buy safety devices. It will save America a lot of suffering and a lot of money in the long run.

Thank you.

Senator DODD. Thank you very much, Zachary. Very good. [Applause.]

Senator DODD. How much farther, Zachary, do you have to go? You are a high blue belt?

Mr. NUSE. I have about two more ranks.

Senator DODD. Two more ranks to go to get a black belt?

Mr. NUSE. Yes.

Senator DODD. Then you will have to come down to Washington to protect me. [Laughter.]

Senator DODD. Tonia, thank you for coming this morning.

Ms. ORTIZ. Thank you. Good morning, Chairman, Senator Dodd, and Senator Jeffords. My name is Tonia Ortiz, and I am currently involved in some programs of the Latin American Youth Center. We brought this shirt from the center for you today as a gift.

Thank you for allowing me this opportunity to express my opinions, concerns, and experiences. Here are a couple of points I wanted to highlight from my testimony, and I hope you will take them into consideration.

My first point, as you have read in my testimony, I refer to a lack of respect and conflict between police and youth. In order for the youth to respect the police and vice-versa, community centers should organize conferences between the two. In these conferences, the police and youth should feel free to express all their opinions without offending each other or taking it personally.

In my second point, I mentioned the negative effects of incarceration. Separating youths from society is not going to change anything. The youth are not learning anybody by getting locked up. Instead of using the money for more jails, they should use the money to open up educational institutions. Alternative high schools should be located outside the city and resemble college campuses.

My third point is in regard to youth having nothing to do. You should develop affordable recreational facilities that offer entertainment like amusement parks. This should be run by the city and would also create jobs for youth.

My last and final point, because of time constraints, are the entrepreneur projects. I think entrepreneur projects are a good idea because they help establish a means of survival. It allows the youth to build on their independence. This, again, creates jobs for the community.

Again, I want to thank you for your time and attention to my testimony and remarks, and I welcome any questions you may have.

Senator DODD. Well, thank you very much, Tonia, for that testimony. It was very helpful and worthwhile. We do talk about preventable injuries and things like seat belts and smoke detectors and bicycle helmets. But preventable injuries can also occur if we would do things to prevent violence from occurring in our neighborhoods. And so the conversation and discussion needs to include that subject as well, and your testimony here this morning helps us tremendously.

I mentioned that next week we are going to focus particularly on that area, and we will hear about some ideas for youth programs, after-school, summer programs and so forth, that offer young people alternatives to crime. The single largest killer of African American males between the ages of 14 and 24 is violence, and we need to try to get a handle on that. So we thank you for the perspective you have brought to the hearing this morning as one of our witnesses.

Ms. ORTIZ. Thank you.

[The prepared statement of Ms. Ortiz follows:]

PREPARED STATEMENT OF TONIA ORTIZ

Keeping kids safe is a subject that everyone is concerned about. During the past few years, violence has increased enormously. From the age when I was 14, I've seen a lot of violent actions going on around me. I've seen a lot of stabbing, shooting and assaults. Three years later, to this day, nothing has changed. Most teens involve themselves in violence because of respect, popularity, power and to get attention. What I mean is that they want people to respect them and be the center of attention. They probably want something they cannot get at home.

Another cause of violence is the disrespect of police officers. Police officers, some not all, have a tendency to harass innocent people because of how they look or act. Things like this end up causing hatred towards the police officers so the youths do not respect the law because they think the law isn't fair because police officers could get away with practically anything. No one is going to pay attention to someone who has no power compared to someone who does. Its like a crumb to a cookie, everyone is more attracted to the cookie than the crumbs.

Also society puts troubled teenagers in a category, like the "bad people" of the city. They put kids in programs separating them from everyone else saying that they're a danger to society. These kids build up hostility and conflict towards others because of the fact that they've been locked up and separated from everyone else. Teens are usually being put down, so they soon end up acting like what they are being called. Many teenagers can't get jobs because of the way they look or because of their background. Because of this they stick to violence in order to get whatever they want or whomever they need because they don't have parents or people to show them the right way.

Instead of society separating and judging kids in a certain way, these kids need help, not psychiatric help but someone to help them get their heads on right, someone to look up to, to give them a job, to give them a new way to take out their anger, to get them out of trouble and to give them a life! People like yourselves will never know what causes violence or how it affects us unless you go out yourself and experience what we experience.

Instead of just locking everyone up you should find out a way to help them. Try talking to them once in a while, its not like they're aliens, they do know how to think and talk.

OUTREACH PREVENTION AND ADVOCACY DIVISION RECOMMENDATIONS

1. LACK OF RESPECT AND CONFLICT BETWEEN YOUTH AND POLICE

In order for the youth to respect police and vise versa community centers should organize police and youth conferences once a month. The police and youth should openly share their opinions without offending each other or personalizing issues.

2. NEGATIVE ASPECTS OF INCARCERATION

Seperating youth from society isn't going to change anything. The youth are not learning anything by getting locked-up. Instead of using the money for more jails, they should use that money to open up educational institutions. Alternative High Schools should be located outside the city and resembling college campuses.

3. YOUTH HAVING NOTHING TO DO/NO RESOURCES

You should develop affordable recreation facilities that offer entertainment like amusement parks. This should be run by the city and would also create jobs for the youth.

4. ENTREPRENEURSHIP PROJECTS

I think entrepreneurship projects are a good idea because they help establish means of survival. This again creates jobs for the community. It allows youth to build on their independence.

Senator DODD. Let me just ask a couple of questions, if I can. I do not want to keep you long, but I am interested in some of your observations and thoughts. You all did an excellent job, by the way. Let me start with you, if I can, Doctor, and you have addressed some of this already, so you will be repeating yourself to some degree. But you have mentioned that so many of our States, just a handful, really, do not have on the books the necessary statutes in place that require smoke detectors. In some cases, as Zachary pointed out, it is only in new construction, not in older homes. You mentioned before seat belts, but States do not necessarily get into other children's safety issues to the extent they should.

Obviously we can pass laws, but we cannot look into every automobile and peer into every home every day to check batteries and so forth. How can we do a better job of getting people to utilize these devices or to insist their children do? What more can be done to maximize particularly parental involvement?

Dr. KOOP. Mr. Chairman, you know as well as I that in prevention, it is education that counts, whether we are talking about smoking or AIDS or the kinds of things we discuss here today. And that is the beauty of the Safe Kids Campaign, which is a grassroots organization. With 164 coalitions in all but two States, it is these informed and concerned parents who are best able to do the educating. And we recognize that something as simple looking as that little safety seat there requires three separate operations every time a mother straps her baby into it. The baby goes in and gets strapped, faces the right way, and then the seat gets strapped in the car. It is easy to forget one of those, in which case it is not worth having done the other two, either.

So we are counting on our coalitions doing this, and we recognize that this is more and more important. And next year, we hope that Safe Kids will get into schools, and that will be another way to have a conduit home-to-parents to remind them about these things.

Senator DODD. I think it was you who mentioned this morning that children even as early as 4 years of age are talking about smoke detectors.

Dr. KOOP. Yes. I was in a house one time with a kid, and as he walked past the smoke detector, he asked his mother, "Does that battery work?" I could hardly believe that you could teach a 4-year-old to do that, but you can.

Senator DODD. Yes. And that will be enough in some cases for a parent to go out and take care of the problem.

Dr. KOOP. Yes.

Senator DODD. How about information dissemination and the role of the Federal Government? I think you are absolutely correct about schools and that children can play an important role with their parents. But can we do a better job here in terms of helping in that effort?

Dr. KOOP. Yes. I am engaged right now at Dartmouth, in the Koop Institute, trying to turn out a different kind of a doctor for the future, and I have become very acutely aware of the fact that 70 percent of what a physician does with patients is health education, and we do not spend 1 minute on that in medical school. So two things we have suggested in our policy report that I suggested be part of the record are, first, to grant States the ability to provide training for primary care physicians to do this very thing, and the other is to provide funds for clinics so that they can include preventive measures as well as therapeutic measures in their services.

Senator DODD. Tonia is here—and when we talk about preventable injuries, we think about very specific things—but Tonia talked a bit this morning about the violence issue. I know you care deeply about that issue as well. The numbers that we have cited—of 8,000 and 50,000 children—what does the addition of youth violence statistics do to these numbers?

Dr. KOOP. It would increase them tremendously. We have sort of drawn the line arbitrarily, Senator, because we call these preventable injuries, and although when there is interpersonal violence in the family, the intent may not be to produce an injury; the intent is to at least threaten somebody or scare them into being injured. So we separate those. But if you were to add the kinds of things that happen with child abuse, with interpersonal violence, I suspect the numbers would be at least double, maybe triple.

Senator DODD. That is the reason why I thought it made some sense to at least reference it in the discussion. And I wonder if, in your opinion, we can use a public health model in order to work on these violence issues.

Dr. KOOP. I think we can, and I think Mark Rosenberg, who will follow us here, is probably the country's expert on the epidemiology of violence, and he can give you some statistics on that.

Senator DODD. I have had an opportunity to meet with Mark, and I agree with you, he is a knowledgeable person, but I appreciate your comments as well.

I am going to take the four points you have given us here—access, subsidies and so forth to low-income families—but I think the chart here on the Medicaid cost is particularly worthwhile. It is costly, but if you look at that total Medicaid cost of $275 and compare that with the cost of what it may have been for Marcus here to be in that hospital and all the particular dollars and cents associated with treatment, it is a fraction of what we are talking about.

Dr. KOOP. But Marcus is out of the hospital now, and Marcus is still having to spend money to do these therapies. And lots of these children who have head injuries from bicycle falls have to go into special education classes, which are ever so much more expensive than mainstreaming.

Senator DODD. That is a very good point.

If I can, let me ask some questions of our young people. One of the reasons why I wanted you to testify, all five of you, here this morning is because you bring a special perspective. Heather and Marcus, you both said it is just "not cool" to wear bicycle helmets. Parents can buy them, and they can insist that you put them on when you leave the house, but you know full well that once you get around the corner, you can also take it off pretty quickly, and parents cannot watch you all the time.

What can be done—and Marcus, you made a couple of suggestions with sports logos and so forth—but what ideas would you have—and I ask all of you this—on ways in which we could promote among young people better efforts in this regard? Parents can buy the helmets and buy the carseats and put the batteries in the smoke detectors. But on some of the things that children do themselves—education, awareness, learning to swim, and learning safety lessons—what can be done to help young people appreciate this more, do you think? Do you have any thoughts on how we can reach your peers, your age group, in these particular areas, to be safer?

Heather, do you want to share some thoughts?

Ms. GIAMBO. I think that in school, they should be telling kids about bike helmets and how they work, and they should get kids who survived bike crashes—they should get them, because kids tend to listen more to other kids than to parents.

Senator DODD. It is encouraging to hear that. [Laughter.]

Ms. GIAMBO. I think that kids should tell other kids about it. And other kids who do not like to wear them should realize that if they do not wear them, the are putting their whole life in danger.

Senator DODD. That is a very good thought. Thank you.

Marcus, do you have any additional thoughts to add on what can be done to convince young people to be safer, particularly in areas like bike safety or even talking to their parents about the smoke detectors and the car seats for infants?

Mr. YOUNG. You do not have to put fear in their hearts. You do not have to scare them by telling them, "If you do not put this on, you are going to die." You have got to make it fun, you have got to make it interesting.

Senator DODD. I agree with that. How would you do that? What are some of your thoughts? You mentioned the logos on helmets. What other ideas would you have?

Mr. YOUNG. Yes, like if it were a Starter helmet——

Senator DODD. How would you change the design of that helmet? Do you like the look at that helmet?

Mr. YOUNG. Well, this color, I would make it a Raiders.

Senator DODD. You would make it a Raiders; so you would have the pirate's face on there?

Mr. YOUNG. Yes, Raiders across here; then you can put Starter right here.

Senator DODD. Starter?

Mr. YOUNG. Yes.

Senator DODD. I think I may get lost on that. What is Starter? Is that an important word to know? Am I showing my ignorance here?

Mr. NUSE. It is a brand that you can get.

Senator DODD. Oh, a brand, okay.

What else? Any other thoughts on that helmet?

Mr. YOUNG. That is what you could do to it.

Senator DODD. All right. So different sports teams and so forth.

Mr. YOUNG. Yes.

Senator DODD. OK. How about the car seats? How would you get your family or friends to use those car seats that Dr. Koop talked about?

Mr. YOUNG. I do not know about that. [Laughter.]

Senator DODD. Well, you did pretty well with the helmets.

Any other thoughts from Zachary or Jena or Tonia on reaching young people on how to be safer?

Ms. ORTIZ. Most of the kids do not really pay attention to other people, and they are not going to think anything is going to happen to them if they do not wear a helmet, unless they experience it. So maybe if they look up to someone, and that someone wears it, they would wear it, too. I do not know.

Senator DODD. How about on TV shows, for instance, so when they are watching their favorite TV shows, the cartoon characters or whatever are utilizing safety devices; do you think that might help?

Ms. ORTIZ. I think that would help.

Senator DODD. Maybe we could get the Simpsons to wear bike helmets.

Mr. NUSE. Yes, that would be cool. [Laughter.]

Senator DODD. What do you think about that, Zachary?

Mr. NUSE. That would be neat.

Senator DODD. I am trying to think of the name of that other cartoon that is far too popular—Beavis and Butthead. I should not even mention the names.

How about you, Jena? Do you have any thoughts? You mentioned safety around pools and so forth. How do you think we could get young people interested? It is one thing to be able to teach it in the schools, but what Marcus and Heather and Zachary have been talking about—how do you make it interesting and positive—I think what Marcus said was a very good point—so that it becomes fun to do these things, and not that it is, "Oh, no, I have got to do this," or "If I do not do it, I am going to get in trouble." There is a whole different point of view if it becomes something you want to do rather than something you have to do. And if you can move into that area of "fun to do" rather than "have to do", you get a lot more people involved in it pretty quickly; don't you think?

Ms. GROSSER. Yes.

Senator DODD. So do you have any thoughts on that?

Ms. GROSSER. I enjoy swimming, and I know a lot of my friends do. And when you start children swimming at a younger age, they learn how much more fun it is, and they learn the safety and how to swim and what to do when they are faced with a situation like I was.

Senator DODD. Well, that is a good point; so swimming is not just something you learn to help out someone who gets in trouble, but it is a lot of fun, too.

Ms. GROSSER. Yes.

Senator DODD. Now, a lot of schools, of course, do not have swimming pools, or they are not in areas that have swimming pools, but there are things like YMCA programs and boys' clubs and girls' clubs, and a lot of cities have public pools and facilities that could be used. So what you are suggesting is that we start early with young people and make it possible for them to be there to get the education and the training.

Ms. GROSSER. All of the 5th grade classes in Elkhart have just completed a swimming course over the last 2 weeks. I enjoyed it, but I feel that that is too old; you are already going to parties, and if you do not know how to swim, you have already developed a fear of water. If you start at a younger age, that is going to help a lot.

Senator DODD. Where did you take the swimming lessons in Elkhart?

Ms. GROSSER. About 2 weeks ago.

Senator DODD. Where was it done?

Ms. GROSSER. A local high school.

Senator DODD. So it was at a local high school that had a pool?

Ms. GROSSER. Yes.

Senator DODD. OK. Thank you very much.

You have all been very, very helpful—yes, Marcus?

Mr. YOUNG. Yes. I was going to add something to this. If this helmet were like a Raiders/Starter helmet like I said it could be, people probably would not even ride their bikes; they would just put it on like a hat. [Applause.]

Senator DODD. You know, I think you are going to have a marketing job pretty quickly. And maybe if you put a beak on it and could wear it backward, it would be even better.

Well, those are some good ideas. You have been very, very helpful in your testimony this morning. It takes a lot of courage to speak before a committee, and I know it is a little intimidating, but all of you did an excellent, excellent job, and you should be very, very proud of yourselves. I know your families are, and your fellow students who are here this morning. You have done a good job in representing them.

So the committee and the U.S. Senate thank you for coming this morning.

And Dr. Koop, it is always truly a pleasure to have you before us at any time, and we will be interested in having you give us a hand maybe in making a few phone calls. Having listened to your schedule over the next 16 days, I am going to be hesitant about doing that, but if there are some key members you might be able to pick up the phone and give a call to on some of these points, we may get back in touch and ask you to help us out on that, if you would.

Dr. KOOP. Any time, Senator.

Senator DODD. Thank you all very, very much. [Applause.]

We would like to call up our next panel. I would like to welcome Dr. Helen Schauffler, Dr. Mark Rosenberg, and Dr. Ted Miller.

I want to recognize the contribution of Johnson and Johnson, who is the corporate sponsor of Safe Kids. They have done a tremendous job and are a good example of corporate involvement, corporate responsibility, and corporate caring about an issue. They have been tremendously helpful and supportive in putting this Safe

Kids program together, and I want the public record here to reflect their involvement.

I also want to recognize Dr. Marty Eichelberger, who is the president of Safe Kids, and Heather Paul, who is the executive director of Safe Kids, for their tremendous contributions. I know there are many others involved on the staff and the board of Safe Kids, but I particularly wanted to reference the president and the executive director.

And I know there are other businesses involved; it is not just Johnson and Johnson. But they have been the lead sponsor, and we thank not only them, but the other corporate sponsors as well for their contributions.

At any rate, let me make my introduction of these witnesses. You have already heard Dr. Rosenberg referenced by Dr. Koop. Dr. Rosenberg has made a tremendous contribution. He serves as director of the National Center for Injury Prevention and Control at the Centers for Disease Control. The Center focuses on attempting to reduce unintentional injuries such as falls, burns, poisonings, drownings, and motor vehicle accidents, and intentional injuries such as interpersonal violence and suicide. Dr. Rosenberg was also part of a handful of Government and community leaders who came together at a dinner last fall that helped me put together an initiative on youth violence called "Ounce of Prevention Program." In fact, that title was coined that evening at that dinner. As a result of that gathering, there is now close to $1.3 billion for Ounce of Prevention-related programs in the crime bill, and my hope is we are going to get that number up a bit.

We tried to get an "ounce" of the money in the crime bill to go for prevention, and Dr. Rosenberg was tremendously helpful that evening.

Dr. Schauffler, we are very pleased to welcome you here this morning as well. Dr. Schauffler is currently assistant professor of health policy at the University of California at Berkeley. Prior to holding this position, Dr. Schauffler worked for the Massachusetts Department of Public Health, directing the State's community-based prevention programs. She will discuss this morning how injury prevention is vital to promoting the health of our Nation's children.

And last but not least, Dr. Ted Miller is director of the Children's Safety Network. He is a safety economist, a phrase which he has coined, and I think a valuable one. In this role, he examines both the cost and the causes of a variety of safety issues ranging from unintentional injury to drunk driving to violence. Dr. Miller became involved with this issue of safety in 1982 while working for the highway administration conducting research. He realized the important questions that needed to be answered, and he saw it as a chance to help people, including children.

Dr. Miller, we welcome you here today and thank you for being a part of our panel.

I am going to ask you to testify in the order in which you are seated, so Mark, we will begin with you. I would point out that any supporting data and information that you have with you today or that you would like to include in the record will be made part of today's record as well. I would appreciate it if you could try to limit

your remarks to 5 to 8 minutes or so, so we can get to some questions.

We thank you immensely for being here. I hope the testimony of the previous panel was of some value to you as you listened to children talk about these issues. As I said, I think young Marcus there is going to have a terrific career in the corporate world of designing children's safety equipment.

Dr. Rosenberg, we will begin with you.

STATEMENTS OF MARK ROSENBERG, M.D., DIRECTOR, NATIONAL CENTER FOR INJURY PROTECTION AND CONTROL, CENTERS FOR DISEASE CONTROL, ATLANTA, GA; TED MILLER, PROGRAM DIRECTOR, NATIONAL PUBLIC SERVICES RESEARCH INSTITUTE, LANDOVER, MD; AND HELEN SCHAUFFLER, ASSISTANT PROFESSOR OF HEALTH POLICY, UNIVERSITY OF CALIFORNIA AT BERKELEY, BERKELEY, CA

Dr. ROSENBERG. Good morning, Mr. Chairman.

I am delighted to be here with you and to be joining with Safe Kids today to highlight the importance of injury prevention.

The National Safe Kids Campaign has done something absolutely extraordinary. They have changed the way we think. And you know how hard it is to change the way grownups think. They saw kids being killed in car crashes, and they said they did not have to die that way. They saw kids being burned beyond recognition and said that did not have to happen. They saw that kids did not have to die from injuries, and they told us that. They saw that these deaths could be prevented, and they got that message out to America. What an idea, and what a powerful message.

How the National Safe Kids Campaign became a key player in the effort to prevent injuries is an incredible success story, but it is far from finished. As you heard today, our kids are still dying from injuries. And to address this, we are mobilizing a wide array of partners, including Government, nongovernmental organizations, academia, foundations, and community-based organizations, to make injury prevention a reality. And it is happening. As Dr. William Fagey, a former director of CDC, likes to point out, he said, "Fourteen years ago, it would have been hard to get 14 people in the same room who were interested in injury prevention." You have seen the crowds here today, and he pointed out that last year, we had a world conference on injury prevention where we attracted 1,400 experts from around the world. It is happening.

Today, I will discuss CDC's activities in the area of childhood injury prevention and try to help you see how your Government is making this happen.

In 1985, the National Academy of Sciences produced a landmark report called "Injury in America." This report stated that the need for strong Federal leadership is to give injury control visibility and develop a program in one place to address the problem of injury. It said there could be a national center for injury control at CDC, and in 1992, CDC established its newest center, the National Center for Injury Prevention and Control, to investigate ways to prevent and control injuries.

CDC's role in injury prevention has three parts. The first is to provide leadership to the injury control community; second, to de-

velop a strong science base to prevent injuries by applying outcome-oriented, prevention-focused applied research to the practical problems at hand; and third, to put service and prevention to work by supporting State and community injury control programs.

Let me start with leadership. We view leadership as having a vision and getting a great team to share in carrying it out. Let me just list part of your team. There is the National Highway Traffic Safety Administration, which has been a leader in the field of injury control since its inception in 1966. NHTSA has been instrumental in the passage of child restraint laws in every State, and as a result, 2,000 children under the age of 5—2,000 children—have been saved by child restraints in the last 10 years.

There is the Health Resources and Services Administration, which helps States to redirect resources to critical childhood injury prevention services through the Maternal and Child Health Block Grants and the Emergency Medical Services for Children Program. HRSA also provided early seed money for States to run childhood through the Special Projects of Regional and National Significance, or the SPRANS grants.

NIH, another important partner, has supported pioneering research on how the behaviors of children and their parents put children at risk for injuries and how these behaviors could be altered.

The Indian Health Service has been injury prevention for American Indian and Alaskan Native populations a reality. In Cherokee, NC, for example, one Indian Health Service nurse noticed that there were too many pedestrian deaths. Her research showed they were all killed in the same place, a place where rocks jutted out into the winding mountain road and forced pedestrians to round a blind corner into oncoming traffic. She blasted the rocks away, built a sidewalk and stopped the deaths; she stopped them cold. To me, that is prevention at its best.

In addition to teamwork within the Department of Health and Human Services, as you know, the Departments of Justice, Labor, Education, Health and Human Services, Housing and Urban Development, Agriculture and Treasury have all recently teamed up to prevent youth violence, another injury epidemic out of control.

CDC has also provided leadership by creating injury control research programs across the country and developing a national research program that is looking at where we go after smoke detectors and after helmets and how we reach into new injury hazards.

CDC is supporting injury control programs in more than 20 State health departments. We brought together 250 organizations around the country and more than 900 injury experts to develop a national plan for injury control, and we have established violence as a major public health issue.

In addition to our leadership role, CDC has been bringing science to bear on injuries. Science really is just clear common sense. It is an approach that we have used to combat traditional public health scourges like smallpox, sexually transmitted diseases and cancer. It is simple: We define the problem, investigate what is causing the problem, find out what works to solve the problem, and then figure out how to do them, how to implement these solutions.

CDC conducts surveillance to monitor trends in deaths, disabilities, and costs associated with injury. We support research to de-

velop and evaluate strategies to prevent and control injuries. We help States and communities develop, implement and evaluate effective injury control programs. We also fund research to find out what works to prevent injuries. For example, it was CDC that supported studies which showed that helmets reduce the risk of nonfatal head injury by 85 percent; or an evaluation of mandatory helmet use law in Maryland that showed that helmet use after the law increased from 4 to 47 percent. And we have just begun evaluating 16 violence prevention programs across the United States to see what will have an impact on reducing youth violence. And we are looking at the impact of family violence on children and their safe development.

CDC provides grants to State health departments to run injury prevention programs. We are putting bicycle helmets on kids, installing smoke detectors in homes, and replacing old batteries in others. We are teaching youth about conflict resolution and preventing children from drowning.

Our efforts in the area of childhood injury prevention will continue to be a high priority. In the future, CDC hopes to focus our work with partners like Safe Kids to help close the injury gap between low socioeconomic status and those children of middle and upper socioeconomic status.

In conclusion, let me identify six P's that I think help to make Safe Kids such a success. Safe Kids was a success because they picked the right problem, the first P, the problem, injury, the leading killer of kids. It previously had been accepted that accidents are part of life.

Second, Safe Kids went to the right place. They were headquartered here in Washington, but more important, they went local. They went to communities, to homes, and right to parents.

Third, they pushed the right products—smoke detectors, helmets, seatbelts and child restraints, products that work.

Fourth, Safe Kids worked with passion.

Fifth, they picked the right partners.

And sixth, most of all, they focused on prevention.

This transformation of the image from injured, burned and dying kids into the image of safe kids—what an idea; what a powerful message.

I hope you can take some pride in knowing that your Government is working hard with partners like Safe Kids to achieve this.

Thank you.

Senator DODD. Thank you very much.

[The prepared statement of Dr. Rosenberg appears at the end of the hearing record.]

Senator DODD. Dr. Miller.

Mr. MILLER. Thank you, Senator.

I direct the Children's Safety Network Economics and Insurance Resource Center, which is one of six Children's Safety Network centers funded by the Maternal and Child Health Bureau. Those centers are funded because children are a very important part of our Nation. One in five children in America is under age 15. That makes child health an important issue in health care cost control.

Today, 102 children came to Washington to talk about their experiences with serious injury. Finding those kids was easy. Each

year, one in four children gets medical treatment for injury. The medical bills alone exceed $5 billion. Adding productivity lost when children are killed or permanently disabled, the monetary costs of those injuries approaches $14 billion—$14 billion for a largely preventable problem.

Health care reform should stress injury prevention. Why? First, because we have a responsibility to care for our children, and injury is the leading cause of child death from age one to age 21. Second, out of compassion for children whose parents cannot afford child safety seats, cabinet locks, and such.

Those resources are important, but our budget is tight. We cannot afford to do everything we would like to do. That brings us to the third reason for saving our children—money.]

Preventing injuries is cheaper than patching them. Let us take some examples. We have talked a lot about bicycle helmets today. Including distribution and fitting, we could put helmets on children for about $15. Each helmet prevents $30 in medical spending. It also saves lives and prevents permanent disabilities.

As my written testimony describes, I have used widely accepted methods to value the productivity savings for our economy, the pain and suffering avoided, and the quality of life preserved. I call preventing productivity losses and quality of life losses "other social cost savings." These "other social cost savings" exceed $400 for every $15 bicycle helmet.

Remember, some of the social cost savings are hard dollars. Auto insurers, fire insurers, the economy, all help pay the bill. For example, every bicycle helmet saves auto insurers $12. My estimates are conservative. They exclude costs to families and employers when parents miss work to care for injured children.

The second example is poison control centers. They offer returns comparable to immunizations. Every $10,000 invested in poison control saves more than $75,000 in medical spending. Yet health insurers do not pay these centers for the services they deliver.

Third, smoke detectors. The cost is $12 to $18 to install. The savings are $18 in medical spending, and $1,225 in other social costs.

Fourth, safety seats. The cost is $40 for a convertible seat good through age 4. Each seat saves citizens $80 in medical expenses and $1,200 in other social costs.

Injury prevention counseling by pediatricians. The American Academy of Pediatrics has a program called TIPP, which stands for The Injury Prevention Program. For children under age 5, TIPP recommends that pediatricians counsel families on injury prevention at 11 well-care visits. The cost is about $70. That saves $60 in medical spending and $580 in other social costs.

I have other examples I could give you of ways safety can save taxpayer dollars—nurse home visitation for injury prevention, which is very effective against child abuse; motorcycle helmets; regionalized trauma care; enforcement of laws against serving alcohol to intoxicated patrons; swimming pool fencing.

The bottom line is that more safety efforts need to be built into our health care system, both now and under any health care legislation enacted. Medicaid or Aid for Families with Dependent Children should buy safety devices for indigent children.

I have taken five safety measures as example. The chart over here shows the cost savings if Congress funded those measures for Medicaid recipients under age 15. This chart is in millions of dollars. The net annual medical care cost savings are $130 million. In addition, we could preserve future productivity for our economy and improve the quality of life of children and families. These added benefits are valued at $3.75 billion annually.

Injury prevention is the answer to a legislature's prayer. It is a chance to help people while saving money. Many parents obviously will pay for some safety measures out of their own pockets. Under health care reform, we cannot leave it to the strained health care infrastructure to fill the gaps. We should provide child safety seats and other proven safety devices to low-income children who need them. We should treat poison control centers, nurse home visitation programs, and regionalized trauma care systems as mandatory contract providers and pay them for their services.

We should ask pediatricians to include injury prevention counseling and well-care for our children. We should assure everyone has working smoke detectors. We should require every swimming pool owner to fence his pool properly. And we should give States incentives to require safety device use.

We need to stress injury prevention in health care reform. Ten years from now, let us make it hard to find 102 children whose lives have been touched by injury.

Thank you.

Senator DODD. Thank you very much, Dr. Miller.

[The prepared statement of Mr. Miller appears at the end of the hearing record.]

Senator DODD. By the way, I would point out that the audience is getting smaller because these children have visits to make now with various congressional delegations. I did not want you to think they were walking out on your testimony. They are just out doing their job, as they promised they would do.

Dr. Schauffler.

Ms. SCHAUFFLER. Thank you, Chairman Dodd.

It is a pleasure to be here to discuss some of the key issues that I think must be addressed within health care reform if we want to reduce childhood injury.

I am Dr. Helen Halpin Schauffler, as you know, from the University of California at Berkeley. Last November, I coauthored a report funded by the California Wellness Foundation that was entitled, "Health Promotion and Disease Prevention in Health Care Reform," that I presented in testimony before the full committee in hearings on the President's bill.

Based on that report, more recently, on behalf of the Partnership for Prevention, I prepared model legislative language that can be incorporated into any of the health care reform bills——

Senator DODD. Terrific.

Ms. SCHAUFFLER [continuing]. That seeks to achieve some of the goals that have been laid out this morning.

Senator DODD. We will make that a part of the record here, and I know that staff has some copies of it already.

Ms. SCHAUFFLER. Yes, that is correct. Thank you.

My goal in preparing the reports and in testifying before you is to try to make promoting the health of the American people, and this morning, promoting the health of America's children, an explicit goal of health care reform, which it is not in most of the bills right now.

I have both professional and personal motivations for pursuing this goal. Like the children who were here earlier, I too have very personal experiences with preventable childhood injury. As a 3-year-old travelling on a city street in Ohio, going about 35 miles an hour in the back of my mother's care, I inadvertently opened the back door. I did not have a safety belt on, and I fell out, landed on the pavement, and had a head injury that required stitches all over the front of my head. I was fortunate that that injury was not disabling.

My younger brother, Eric, however, was not as fortunate. As a teenager in Connecticut, he was driving home late one night from his girlfriend's house and was in a car crash. He did not have his seatbelt on and was thrown from the car and died. So my family knows first-hand the tragedy of these injuries, and needless to say, I am quite motivated to be here and to speak to you this morning.

Health career reform I think provides us with a very important vehicle to try to achieve some of the goals that have been laid out by Dr. Rosenberg and Dr. Miller as well as Dr. Koop this morning. And I feel confident in saying that all of the health care reform bill that have currently been introduced into the Congress need to be considerably strengthened to address childhood injury in the United States.

I want to focus just on three areas this morning that I think require the committee's immediate attention. The first is accountability. We need to make reducing childhood injury an explicit goal of health care reform and hold health plans, States, State and local health departments, and community-based programs accountable for reducing childhood injury.

To begin with, I think we need to develop uniform measures of childhood injury established at the Federal level to be included as part of the comprehensive set of national performance measures that most bills call for. Those are not included in most of the bills at this point.

I think we also need to hold primary care providers and health plans accountable for providing the kinds of injury prevention counseling that several other members have mentioned this morning. A recent study commissioned by the Safe Kids Campaign found that nearly 60 percent of parents report that their child's physician has never counselled them about injury prevention. And I think that we need to make clear our expectation that they should be doing that and begin to hold them accountable for doing that.

Responsibility for collecting and reporting uniform data I think should be given to State health departments and, at a minimum, States should be expected to meet the goals that have been set out in Healthy People 2000. And I would like to see use us those goals and objectives in Healthy People as at least a baseline for accountability for States.

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Second is public policy. As we have heard, one of the most effective and efficient means of reducing childhood injury is through the adoption of public policy that mandates sp[illegible]ic safety precautions. While many States, as Dr. Koop laid out, have enacted legislation and adopted regulations addressing some of these areas, many others have not, and most States do not have comprehensive laws in place. Nine States still do not have any mandatory smoke detector laws. Twenty-two States have not adopted scald/burn prevention language in their building codes. Forty States have not mandated bicycle helmet laws. And while child occupant protection laws have been adopted by all 50 States, they vary tremendously in the age requirements of the children, the exemptions, the enforcement procedures, and the penalties.

I think goal of health care reform should be that all 50 States adopt a[illegible]nplement comprehensive child safety legislation.

Third and finally is support for public health and community-based programs. Presently, less than one percent of total health dollars are spent on population-based prevention programs. I think it is essential that health care reform provide for more stable and adequate funding for public health and population-based prevention, which includes support for things like poison control centers, injury prevention units in State and local health departments, and injury prevention in community health centers.

In addition, Federal funding is needed to support the development and implementation of community-based programs like the Safe Kids Campaign, which I think is a model of private-public partnership in trying to implement prevention at the community level. It is only at the community level, through public education efforts, through local monitoring and enforcement of laws and regulations, and public participation in these programs, that we will realize our goal of reducing unintentional injuries.

I want to conclude by reiterating that our Nation's children are at risk. Their leading cause of death and disability is unintentional injury. I urge you and the other members of this committee to seize the opportunity before you as you debate and hopefully pass health care reform to increase access to effective injury programs and resources and seek to protect all children, regardless of what State or community they live in, against unintentional injury.

The children who were here today are evidence and support that childhood injury prevention must be an integral component of health care reform. The burden is on many, including this committee, to protect future generations of children and to potentially save billions of health care dollars on injuries that never ought to have happened.

I would be happy to work with you to achieve this goal and to answer any questions you might have.

Thank you.

[The prepared statement of Ms. Schauffler appears at the end of the hearing record.]

Senator DODD. Thank you very, very much, Dr. Schauffler, and as I said a moment ago, we will take a copy of your model statute or language and take a look at it.

Let me begin by asking you what I will be asked, assuming I can put together some language to talk about a benefits package and

so forth that includes these things. People are going to say, look, there is not a single constituency in the country that does not have a degree of legitimacy about some aspect of this health care issue. And everyone can make a strong case for why we ought to include each proposal put forth.

Again, you pointed out that while there are gaps in certain areas, a lot of States are moving aggressively in these areas to cover some of these questions.

But they are going to say, "Senator, we want to help you out, but people just do not want taxes raised, they are worried about this health care bill getting out of hand." This is really a scenario where parental responsibility ought to be the emphasis rather than subsidies.

And yet we know that $15 or $20 for a helmet may not sound like much if you live in a relatively affluent suburb of this country, but if you are living in the inner city of Hartford or Bridgeport or New Haven, trying to make ends meet on a welfare check, $15 looms larger. And how much we put into programs—people are wondering whether dental services are going to get included, and whether mental health will be included. So putting something in for a bicycle helmet is nice, but in the prioritizing of these things, how do you make the case?

I presume that is basically the question I am going to be getting. And if you were sitting here, what would your answer to that question be in the context of everything else, particularly as physicians and people who are aware of the whole panoply of issues out there. In the prioritizing, you tell me what your answer is when the debate comes down to subsidizing helmets or mental health or dental care. You cannot do everything; you have to make a choice.

Mr. MILLER. I think what we are asking you to do is to give yourselves more breathing room. We are telling you that we have things that we have demonstrated through careful evaluation, that actually, if you buy them will reduce your medical spending, which means they are going to reduce the cost of that health care reform package.

And our studies also show that low-income children will use them if they can get them. There is a study that some of Mark's staff has done that shows that among low-income children who have a bicycle helmet, 85 percent of them use it.

We know that if we look at child safety seat use among the middle class, 90 percent of children wind up in a child safety seat. But if you look at low-income children, only 40 percent are restrained. And I should tell you that safety belt use among zero to 4-year-olds in low-income families is the same as safety belt use in higher-income families. The difference is in use of child safety seats, and that difference results because they do not have those seats.

Senator DODD. Do they have the cars?

Mr. MILLER. We are talking about children who were actually involved in crashes with those statistics. So these were certainly children who were in cars.

Senator DODD. I know they are in cars, but my point is that many of those families do not have automobiles; they are probably riding in someone else's car, aren't they?

Mr. MILLER. Well, what frequently happens in the lower-income community is that five families perhaps will own one car jointly, and they each use it 1 day of the week. We need a child seat in that car.

Senator DODD. Yes, I agree.

Dr. Rosenberg?

Dr. ROSENBERG. I would add a couple of things. One is the payoffs. First of all, people have not thought about injuries as a preventable health problem. They really do think about it as just the cost of living in today's world. So we do have to transform that notion that they are preventable.

The next point is that the payoff is immediate. If you put some money in for prevention of cancer programs or prevention of heart disease programs, the payoffs to those programs may be 20 or 30 years down the road, as we change our diets, as we start to exercise more. The payoffs of preventing injuries that you prevent today, the payoff is tomorrow. It is immediate because the costs would be immediate and the savings are immediate. You do not have to wait 20 or 30 years.

The third point I would make is that in injury control, we have heard a lot about changing behavior, but there are also very important ways that we change the environment that once you put them in place, start savings today and tomorrow and go on forever, with no change in behavior required.

If we change the surface of all the children's playgrounds in Connecticut, where I bet you grew up, and they were concrete or asphalt, and we send kids up to the heights of sliding boards where, if you sent a worker up there, by law he would have to wear a helmet — we send kids up that high over a concrete surface, and what happens is that kids fall off, and they get serious head injuries hundreds of thousands of times a year. We know that we can change the surface of the playgrounds—take the asphalt or the concrete out, put in soft surfaces—and prevent these head injuries.

Prevention at work tomorrow, forever, does not require any change in behavior. It is automatic. It is the same as making collapsible front ends of cars; the same as redesigning floors so that when older people fall, it is soft, so they do not; the same as having automatic sprinkler systems to prevent the fires. There are things we can put in place today, automatically, that will work with great payoffs.

We need to go beyond that, and my fourth and last point is that we have these products that work now because of research that was done. However we finance it, however we support it, we have to keep those research efforts up. There are very exciting things in the wings that will not be paid for as part of health services, and we need to make sure that this research in how to change the environment and how to change behavior goes on, too.

I wish I could say the problem of financing them is simple. It is a hard problem, but an important one with bit payoffs.

Senator DODD. I was just trying to think, and I remember the parking lot of Saint Thomas the Apostle Church, the playground where I grew up. What kind of a surface could you put down in order to keep the parking lot?

Dr. ROSENBERG. You could probably park on wood chips—but I do not know if kids should be playing in parking lots.

Senator DODD. Well, you have to appreciate what a parochial school was like.

Ms. SCHAUFFLER. I would also like to add that perhaps it might help in response to your colleagues if you could speak less categorically and more broadly about prevention. I think that if preventive services, and particularly age-appropriate, periodic health exams, are covered in the benefit package, which they are in many of them—this counseling is not something in addition; it is part of that visit, so there is no added cost. As long as you are covering the basic preventive visit, and you set the expectation that the counseling is part of that visit, there is no added cost. But it is making clear the expectation.

I thin the same thing with public health—as long as funding is made available in the bills to support public health programs, and at the Federal level you establish a goal that reducing injuries is your expectation, then those moneys will be used by States to help reach that goal. But you do not take a very categorical approach and say "x" amount for injuries, "x" amount for AIDS, "x" amount for this.

Senator DODD. I agree with that, yes.

Ms. SCHAUFFLER. So I think we need to speak more broadly and get ourselves out of these narrow little boxes that we find ourselves in in advocating for prevention.

Senator DODD. That is a very good point, and it relates in a sense to the next point I would like to raise with you, which is the physician awareness concept. I remember being startled a few years ago to discover that basic nutrition was only taught at a handful of medical schools in the country. I gather that has changed now, or at least, I hope it has changed, with all the talk about it——

Ms. SCHAUFFLER. Not much.

Senator DODD [continuing]. Given the importance of being able to talk to patients just about nutrition as a part of a general rap on how you can avoid the kinds of problems people have. So particularly for your pediatricians, this has to become part of the seamless garment of the things you talk about. So in addition to the immunizations and the other things doctors talk about as part of their checklists, this also becomes part of the routine checklist.

Are there ways in which we could insist upon that?

Ms. SCHAUFFLER. We are making some progress on this in San Francisco. The Bay Area Business Group on Health is now working with the State of California as well as all the health clinics in the State of California, conducting annual patient surveys, asking patients—who we believe are probably the best reporters—whether or not their physician talked to them about various items on the checklist. That information is being aggregated at the plan level so the plans can see what their performance is; that information is being given to consumers so that consumers can evaluate that in choosing health plans. Information is power. Once you begin to collect information on an item, people start to pay attention to it, and the plans are now working with the physicians to try to get them to provide more of these services.

So I think it involves many, many people, but what we are learning in San Francisco, anyway, is that if we start to measure it, then everyone begins to pay attention to it, and all of the parties involved—the health plans, the physicians, the State—are all working together to try to encourage this behavior. But I think it is going to take a long time, and physicians, as Dr. Koop pointed out, do not get this training in medical school.

So if there is some way—I know that in many of the bills, there is an emphasis on increasing training of primary care providers, physicians as well as nurse practitioners and physician assistants—if there is some way we can mandate that some training in prevention is part of that core primary care training, I think that would also help.

Senator DODD. I am wondering—and I will ask the two of you to respond to the same question—I have tremendous respect for the American Academy of Pediatrics. They just do a terrific job, and have been tremendously helpful on any number of pieces of legislation involving young people. But I am wondering whether, in terms of national conventions and such, if there is or has been an emphasis on this particular question. I do not know if that is the case; do you know?

Dr. ROSENBERG. I think that injury has been emphasized most of all by the pediatricians, because they see it as a childhood problem. And it is the way that we sacrifice our kids today. Injury is the problem that they deal with in facing grieving parents, in facing serious injury and hospitalization. That is what they deal with every day, and they see it. So I think they are starting to do a good job, and I think that other medical associations—the AMA and their focus on intentional injury or violence, the recent campaign; they recently had a meeting with Janet Reno and Secretary Shalala, speaking jointly about health and justice and family violence. So other medical professional organizations are getting involved.

I would also point out that it is important to get the physicians when they are young, and through comprehensive school health education, through teachers and through schools, you can get those physicians before they are in medical school, when they are 5 years old, and start training them in school. So it is a way to reach a broader audience, but also a way to start to get them to incorporate it into their minds through this comprehensive school health education—teach about injuries at the same time you teach about AIDS, at the same time you teach about STDs and heart disease, but work it into the curriculum at every level before they are ready to graduate.

Senator DODD. I think that makes all the sense in the world, and maybe there are ways in which we can use the bully pulpit here to emphasize that particular point.

Dr. Miller, let me ask you to respond to the same question, but add an element for you. You have talked about the significant cost. We are about to consider a major piece of reform in health care in this country, and one of the major groups or organizations expressing the most concern is the private sector, the business community, about what this is apt to do to their costs. We are fooling around with 7 percent of the economy of this country, which is not insig-

nificant, and what changes we make could have a profound impact on the economic well-being of our Nation in addition, obviously, to the health care of this country. So there is great concern there about rising costs and adding to the costs of doing business.

Yet we have seen here a corporate sponsor like Johnson and Johnson, with Safe Kids, and I understand some bicycle dealers in the private sector are not selling bikes without the family taking a helmet with them, as one example. Private hospitals are saying you cannot take the newborn child out of the hospital unless you also have a car seat; this is the way we do business here. Those are two very fine examples. I wonder if you might know of some additional ones where we could get more of the private sector involved, who are very cost-sensitive to any expanded costs to health care, which obviously go right to the heart of prevention, in a sense. Perhaps you know of other examples where the private sector has been a forceful advocate in this area, and what more might we do to get them involved.

Mr. MILLER. I think one of the things that we need to do is to educate them a little. We have done a study that looked at what portions of employers' fringe benefit spending on health-related issues went for injury, and it was 29 percent. That means three of every 10 fringe benefit dollars that they spent on sick leave, on medical insurance, on workers' comp go out the door because of injury. That is a big bill.

Senator DODD. Preventable injury.

Mr. MILLER. Injury is virtually all preventable.

The second point there is that there are employers who have become aware of some of that. We did a set of case studies for NHTSA where we looked at the programs for highway safety that some employers have put in place in terms of their on-the-job employment and also in terms of getting their employees to be more safe off-the-job in their cars and getting their families to be more safe in their cars. They saved a pile of money doing that. They typically saved about $50,000 for every million vehicle miles their fleet travelled.

P.J. Rollard Tobacco, I remember, had major reductions in their insurance bills from their insurers, hundreds of thousands a year, because of what happened to their safety record.

So we really have seen some employers who have gotten this message, and I think that there is a movement afoot—for example, in the Washington Business Group on Health—to really start making businesses more aware of how profitable it can be to cut injuries.

If you have an employee who gets hurt, or his child gets hurt, and that child's injury costs $25,000, more than half of health insurance in this country right now to employed workers is really employer self-insurance. The employer has appointed some health insurer as an intermediary, but ultimately, the employer takes the money out of his pocket to pay the claims. One $25,000 claim for a company that is making a typical profit margin means they are going to have to make a quarter million dollars in sales just to pay for that one injury. That is a lot of sales.

We would have substantially more growth in our gross national product every year if we could just wipe out injury. So those are the messages I think we can give business.

Senator DODD. Those are great examples. If you have some additional ones, I would be interested if you could send them to us. I find that sometimes specific examples are the best kind of data to use, rather than broad abstractions. No one ever thinks they fit into some broad set of numbers, but they can identify with a particular industry or business, so that is particularly helpful.

Mark, you spend a lot of time on the violence issue. Ted, you are probably right; when we talk about preventable injuries, most injuries are preventable—the car seat, the smoke detector, the bike helmet and so forth. And if it were not for youth violence, we would be looking at some seriously declining numbers in violence in this country. Adult violence is dropping dramatically. It is really very encouraging. Where we are getting an explosion that throws all the statistics off is in youth violence. It is just incredible. So to my mind, it sort of fits into this area because we have come up with some thoughts and ideas, and certainly CDC has, on things that could work to reduce the youth violence that is occurring today.

Can we integrate this at all, or is there deep hostility within certain constituencies to talk about violence, the kind of criminal youth violence, along with the subject of seatbelts and bicycle helmets; and if so why?

Dr. ROSENBERG. I think there had been. I think that if you look at the history of injury control, people really came from two separate camps. There were people with a longstanding interest in preventing what they called injuries, and that included only unintentional injuries. And they said that the way to prevent these injuries is to reshape the environment, is to put helmets on kids' heads, to put airbags and seatbelts in cars and redesign the front ends of cars, and to make safer stairs, and smoke detectors. They said that is the main way to prevent these injuries.

And then there were the people on violence, who said that actually, the way to prevent intentional injuries is you have to change behavior; you have to change the way people behave because intention is so important. And they were separated, and the people who worked on unintentional injuries did not want anything to do with violence.

What has happened over I would say the last 10 years—and if we have contributed anything to this movement, I hope that CDC has played a role here—is that the people are starting to come together, and they have seen that unintentional injuries involve a large measure of behavior. It does no good to have a car seat if you do not buckle it up. You have to affect behavior to prevent unintentional injuries.

Senator DODD. And what about drunk driving? That is behavioral. I mean, the reason 50,000 people lose their lives is because of that behavioral condition.

Dr. ROSENBERG. That is right, and you use education, you use public policy, you use harsh enforcement measures, whatever you can, to change behavior. And the people in violence are starting to see that you can also change the environment—the places where kids grow up, what they have to turn to, the accessibility to fire-

arms—there are a lot of common measures that work on both sides, and they have come together.

Senator DODD. Good.

Dr. ROSENBERG. One of the great success stories is an Injury Control Research Center that was started in San Francisco by two people who came out of the unintentional injury mode. They submitted a proposal to the California Wellness Foundation that was looking to spend their newfound millions of foundation dollars, and they said why don't you spend it on youth violence prevention. The California Wellness Foundation accepted this proposal from two hardcore unintentional injury people and started the biggest foundation project in the history of this Nation to prevent violence—a $30 million project by the California Wellness Foundation to prevent youth violence in California, started by people from the other camp.

They are seeing that there is lots in common. The people who suffer the most from both are the people at risk. They are poor people, less well educated, without jobs, without opportunity. They are at the highest risk for both types of injury.

So I think they are coming together, and I think there is lots to be achieved by bringing them together.

Senator DODD. I am glad to hear you say that.

Would either of you like to comment on this as well?

Mr. MILLER. Yes. One comment that I would make is that I also think that there is a need for the violence community to start understanding, for example, that drunk driving is violence. It is illegal, it mains, it kills. And I would caution you about those statistics that say that adult violence is dropping. That may just be that police departments are getting their hands fuller and fuller between drugs and youth violence, and therefore, the amount of violence that is getting reported into police departments may be dropping.

I think that we at least do see sort of a stability in adult violence in the national crime survey.

Senator DODD. Maybe that is a better word to use.

Mr. MILLER. But I do not think we really see a decrease in it.

To go back more directly, though, to your question, I think that increasingly, the two communities are talking to each other, and I think that is very healthy. I also think that we owe a great debt to CDC for trying to get us more demonstrated, workable techniques for preventing violence. There are many things that people are doing that make sense, that have a lot of imagination to them to prevent violence right now. We are probably 2 or 3 years from proving that many of those work and being able to do the kinds of numbers on violence prevention that I can do now on unintentional injury.

I also think that child abuse is a huge problem and a problem that we have really got to address much more strongly in this country and that a lot of the violence that we see starts with child abuse and neglect at very young ages. We do not detect that very well, and we do not intervene in it very well.

There are 2 million children a year in this country who will be abused, neglected, or raped. That is about one in every classroom. That is absolutely unacceptable.

Senator DODD. Dr. Schauffler?

Ms. SCHAUFFLER. I think I would only add, just to reiterate Dr. Miller's point, that I think we do not have as hard evidence in terms of what really works well in preventing violence as we do with some of the unintentional injuries, so it is difficult to be as prescriptive in terms of what we would recommend.

I think we can look at other areas of prevention for possibly fruitful approaches. Obviously, I think the kind of legislation that the Senate and the House just enacted in terms of reducing the availability of certain kinds of firearms is important legislation. I think we have seen that taxes, in terms of reducing access to cigarettes for young people, are very effective, and we might want to experiment with using taxes on firearms and ammunition to similarly make those more expensive to obtain for younger people.

I think the kinds of community efforts that have worked in other areas of prevention might work as well in violence, and then other kinds of regulatory approaches as well.

I think we need to take a comprehensive approach and see where our successes have been in other areas and try them out, but I think we are really at a much earlier stage in our knowledge than in many of these other areas.

Senator DODD. Well, I think you are probably right that some areas are pretty well-established. When you have a good after-school program for kids in a community, with the opportunity for them to be someplace other than the bad alternative, there is no question about what can happen. And I do not disagree that it is a little more difficult, more amorphous because of the underlying problems—it is work, it is jobs, it is housing—there are many other elements that contribute to youth violence.

My concern is that despite the fact that they may be more difficult prescriptions, less targeted and less focused because the problem is more complex, that because that is the case, we are then going to get into a separation. I think there is a wonderful potential here for a coalition to use the "intentional/unintentional," dividing lines here to come together and be very powerful and very effective for children. The danger is if we start breaking it out it dilutes the potential power that can be brought to the question. And if we break it on the basis of the prescription, it is more difficult to identify, so we lose a head of steam that I think is tremendously potent and valuable.

As I said, a lot of these problems are spreading. A few years ago you could pretty much draw lines on maps as to where youth violence really existed, and that is no longer the case. We have 130,000 kids bringing guns to school every day in the United States; one out of five are bringing a violent weapon to school. Now, whether intentional or unintentional—they are trying to defend themselves in most cases. They are not out as perpetrators of crime. They are frightened to death. And yet the mere possession and what happens, whether it is intentional or unintentional, the fact is you have got a kid lying on the steps of New Britain High School at 7 a.m. in the morning who has been shot, or a 7-month-old child in her grandmother's arms in New Haven the other day who was shot and killed because a kid drove by and shot up the

house. So intentional or unintentional at that point is really a distinction without a difference.

So I would hope we could break down some of those barriers. Again, I think there are some very clear things we can do in the areas of smoke detectors, carseats, and so forth, and we ought not to waste a lot of time, and get about the business of doing that. But if we can broaden the coalition to deal with those other issues, it can be tremendously valuable. And as I said, these issues are spreading out into suburban and rural areas, and today, no one feels particularly safe with their kids in many communities that, only a few years ago, you could pretty much count on as being "safe" from that kind of activity. So unfortunately, the violence issue is spreading.

I really appreciate all three of your responses to that particular question.

Mark, I loved your quote, "kids are killing kids, and we think it is a fact of life in this country. People thought smallpox was a fact of life, too, and today it has been eradicated from the face of the earth." The issue of how doctors can stop youth violence is a more difficult issue; where the physician comes into play, I think it is a broader set of questions.

Dr. Miller, I wonder if you could give us a guesstimate on the monetary cost of youth violence. Have you pulled out some numbers or separated them at all?

Mr. MILLER. I would be happy to supply that for the record. I have the numbers in my computer at home, but my computer in my body at the moment is not functioning quite right. I believe it exceeds $100 billion a year, but let me supply the correct number for the record.

Senator DODD. I did not know what Dr. Koop was going to say when I asked him if you expanded the definition of injury to include youth violence, and I think he said it would triple or quadruple the numbers we are talking about here.

Mr. MILLER. That is an exaggeration. Unintentional injury is the number one killer and the number one injurer—or, the number one cause of disability for children—not intentional injury. It does not switch as you get to adulthood, though. As you get to adult, it depends in part on how you define suicide; is that violence, or is it not violence? It is a very difficult question.

Ms. SCHAUFFLER. But wouldn't it vary by subgroup of the population—the young black male, for example?

Mr. MILLER. Yes, it would. But overall, the number one cause of medical spending for children is unintentional injury in this country.

Dr. ROSENBERG. Although again, it raises your point, Senator, where you said the power, if you could combine both—we are really discussing which is number one and which is number two, and they are both injury. They are both injury, and injury is not perceived as a preventable problem.

Mr. MILLER. I get very upset when I look at the mortality statistics, and they have that division there.

Senator DODD. How do they divide it? What do you mean?

Mr. MILLER. The mortality statistics divide unintentional injury, homicide, and suicide. And what happens, as a result is that when

even the injury community talks about where injury ranks in the mortality statistics, we often undercount our own problem because injury is clearly the third leading cause of death in this country. And it is only when you start breaking it up that pieces of it trickle lower and lower on the list, and it becomes, I think, the fourth, fifth, and seventh, or something. That is not exact; but they are still all up there in the top 10, but it——

Senator DODD. It dilutes it.

Mr. Miller [continuing.] It dilutes it, yes.

Senator DODD. This has been very, very helpful. I may have some additional questions I will submit to you, and there may be other members of the committee who will as well. But this has been very, very helpful. And again, I will make an effort with some of the points that have been made to see if we cannot include them in the health care bill for consideration.

I am going to focus particularly on children in my effort. Everyone has different things they want to worry about, and they are all legitimate to one degree or another. My areas of focus and attention will be prenatal care and children, and not just zero to 3 or zero to 4, but I am very concerned about adolescents and the number of visits they make to hospitals and so forth. There is a tendency that once children start to get their second set of teeth and a pimple here or there and so on, they lose that cuddly, cozy kind of image, and the willingness of people to do more seems to drop. So we have got to understand that up until the age of 18, we are dealing with children, at least legally, in our society. So we are going to put a lot of attention on that as we consider the health care legislation.

I thank all of you for what you are doing, the work you have done, and your continuing involvement in these issues. Your testimony has been very, very helpful, and I thank you for being a part of this today.

I think that covers it with our witnesses. I want to thank the staff here on both sides for helping us put this together today, and again thank Safe Kids, Dr. Koop, Johnson and Johnson and others, for their tremendous work. We will stay-tuned, stay in touch, and hopefully, begin to get some heightened interest in this subject matter.

[Statements and additional material submitted for the record follows:]

Testimony of C. Everett Koop, M.D.

Good morning, Chairman Dodd and members of the Subcommittee. I am Dr. C. Everett Koop, Chairman of the National SAFE KIDS Campaign. First, I would like to commend you on your longstanding efforts to reduce childhood injury in this country. Five years ago you chaired a landmark hearing on injury prevention, and today you focus again on this issue as America grapples with health care reform. Thank you for your work.

I come before you today to speak of unintentional injury to children -- the futility of it, the heartbreak of it, and the cost of it. Unintentional injury is still the number one killer of children nationwide. Nearly eight thousand children die each year from unintentional injury -- claiming more lives than all other childhood diseases combined. During the time it takes to hold this hearing -- one child will die and nine children will become permanently disabled as the result of an unintentional injury.

(CHART UP FRONT)

Thirteen million children receive medical treatment each year for unintentional injuries. Mr. Chairman, that's one in four. The cost is staggering -- 13.8 billion dollars.

Senator Dodd, you know that in 1989, I came before this subcommittee to relay the same message that our kids and experts will convey to you today: that good preventive measures save families untold suffering. However, today in 1994, we have an additional message: that injury prevention will also save our health care system billions of dollars. All of us in the health policy community are searching for ways in which optimal care can be delivered cost-effectively.

I speak today as a long-time pediatric surgeon, a former Surgeon General and currently as an advocate for health reform. For 35 years I was on the front lines of childhood injury. As Surgeon in Chief at Children's Hospital in Philadelphia, I saw thousands of children wheeled through our emergency room -- victims of traffic crashes, pedestrian injuries, residential fires, scald burns, bike crashes, near drownings, or poisonings. Helping many of these children was my life's work and therefore enormously satisfying. But it was painfully frustrating too -- many of these injuries could have been avoided. It is very difficult to tell agonized parents that the death or permanent disability of their child just didn't have to happen. Today, with such devices as safety belts, child safety seats, bicycle helmets and smoke detectors -- 90 percent of all unintentional injuries can be prevented.

As Surgeon General I suppose I am best known for the high profile directives I made in regard to smoking and AIDS. However, some of

the work for which I am most proud were my efforts to help build grassroots movements. In the area of childhood safety, I knew that families and children themselves had to hear more about the need for wearing safety belts and bike helmets, more about the vital importance of working smoke detectors and parental supervision of small children around tubs or pools. I also knew that this message had to come from the community itself to be effective . In 1986 I was therefore very pleased to accept the chairmanship of the NATIONAL SAFE KIDS Campaign --which, to this day, is the only organization solely dedicated to the prevention of unintentional childhood injury. Chairman Dodd, when I testified before your subcommittee five years ago, there were 40 SAFE KIDS Coalitions. Today, there are 170 in nearly every state. These thousands of committed volunteers and professionals have helped to pass the first bike helmet laws in their states, smoke detector ordinances and close the loopholes in child passenger safety laws.

The National SAFE KIDS Campaign was born in 1987, and since that time, there has been a documented decrease in certain injuries. We are especially proud of our work in the area of bicycle helmet legislation. In the past seven years, the National SAFE KIDS Campaign and the local and state coalitions have helped pass bike helmet legislation in many states. Since we implemented The National SAFE KIDS Campaign Bike Helmet and Bike Safety Awareness Strategy, helmet use among children has increased from 1% to 15%. We have three other very successful programs in the areas of scald burn prevention, residential fire safety, and SAFE KIDS BUCKLE UP, a child occupant protection program. But there is still much work to be done, and this hearing is a part of that process.

I am joined today by others who will testify. The adults in the group are qualified to speak based on their credentials. The four younger participants have arrived at this hearing room by way of circumstance. Each one has had his or her life changed forever by childhood injury. Each one has come face to face with life-threatening injury, and their grave experiences support our health reform proposals in a way that is far more compelling than scientific studies. Only four of our SAFE KIDS will testify before you, but they ar not alone. In Washington this week are 102 kids who are survivors and heroes of injuries I know all of us wish never happened at all. Many of these kids know the trauma of emergency room care, weeks in the hospital and months of rehab; and many chaperones here today are parents who remember the worries--for their child's health and their family's budget. They are the National SAFE KIDS Summit participants, and right now I would like them to stand and be recognized...

(MOTION FOR CHILDREN AND CHAPERONES TO STAND)

Chairman Dodd, you know that "an ounce of prevention" makes good sense when it comes to deterring young people from crime. In our

case dollars spent on unintentional injury prevention results in millions of dollars in medical cost savings.

For the past year I have been an active spokesperson for health reform. At the same time as we must improve the level of care for millions of Americans, we must also find ways to cut staggering health costs.

(HOLD UP REPORT)

I would like to submit for the record the National SAFE KIDS Campaign health reform policy report. It cites the simple, low-cost devices that really work saving lives and money.

For instance, take this bike helmet.

(HOLD UP BIKE HELMET.)

As two of the children testifying here today will tell you, bike helmets like this one can save hundreds of lives a year, as well as the very serious, long-term brain injury that can result from a bike fall. As one parent has said, if only parents could know that when they send a kid out on the streets without a helmet he or she could return and never be quite the same child again.

(HAVE SOMEONE DISPLAY SEAT AT SIDE OF ROOM)

Child safety seats could save 500 lives a year if they were used correctly and for all young children. Our studies show that in 1991, child safety seats saved 180 lives and prevented 70,000 injuries. However, only 25% of low income parents use them, while 75% of all other children are restrained. Certainly, we must all do a better job of convincing families that their precious infants are indeed NOT safe in their arms in a moving vehicle.

(HOLD UP SMOKE DETECTOR)

90% of all children who die in fires lived in homes without working smoke detectors. Sixteen of the children here today have survived fires and know the importance of working smoke detectors. We will hear from one in a few minutes.

As we deliberate over what could be major changes in the way we deliver health care in this country, we know that the federal government has an excellent opportunity to lead the way by putting prevention up front, where it belongs, in health reform.

The National SAFE KIDS Campaign hopes the testimony delivered today will fully support the fact that there is no better health care investment than in childhood injury prevention.

Here are our recommendations:

- First, that every child should have access to a broad range of injury prevention services. For instance, the federal government should provide subsidies to low income families to assure their use of child safety seats, bike helmets and smoke detectors.

- Second, That the federal government also should provide incentive grants to those states which are saving lives and dollars by having strong laws related to traffic safety and safety belts, bike helmets, and smoke detector ordinances, and antiscald plumbing codes. Michigan's child safety law, for example, has shown a 25% reduction in injuries, and New Jersey's bike helmet law reduced deaths of children by 80% and injuries by 40% in the first year after its enactment.

- Third, grants to fund training activities for primary care physicians to do more injury prevention counseling. As you know, I believe that there should be many more primary care physicians in this country by the next century. Research shows that primary care physicians can do much more to counsel children and their families on ways to prevent injury.

- Finally, that the federal government also should expand grants to community health centers to include injury prevention services.

Childhood injury prevention is also a state responsibility, and the National SAFE KIDS Campaign will continue to urge states to pass legislation and strengthen enforcement of those laws already on the books.

For instance, there are sill nine states that have no mandatory smoke detector laws when 12-hundred kids are killed annually in residential fires, and over 11,000 are injured.

In the area of traffic safety, much progress has been made. All but two states have passed safety belt laws. However, many states have major loopholes in their child occupant protection laws.

In are area of bike helmets that reduce the risk of brain injury by almost 90%, ten states have passed mandatory use laws. Our local and state SAFE KIDS coalitions no doubt will work doggedly to increase this number of states that attempt to protect their children from head injury.

Finally, I see injury prevention as a community responsibility. We all have a role to play in keeping children safe. The National SAFE KIDS Campaign recommends that businesses, physicians, insurers, schools, parents, and other members of the community work together toward national efforts to curb childhood injury.

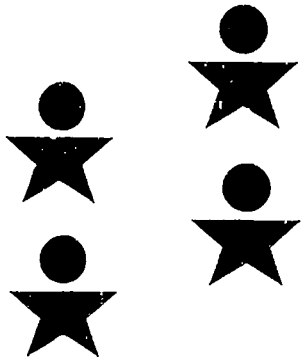
The National SAFE KIDS Campaign believes that immediate legislative action is needed by the Clinton Administration to make sure that all our kids are "safe kids".

I would now like to introduce four young people who will speak on behalf the dozens and dozens of new friends they have made here in Washington, all participants of the SAFE KIDS Summit.

Heather, Marcus, Jenn and Zack could be anyone's children, or anyone's grandchildren -- doing all the healthy, ordinary things that children do. They will tell you their stories, and hopefully leave you thinking about how best to protect your own, and our nation's children.

Thank you.

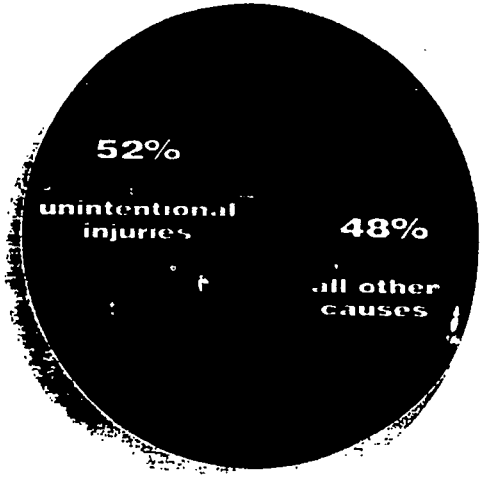
One In Four Children (13 Million) Receive Medical Attention For Unintentional Injuries Every Year



National SAFE KIDS Campaign

How Do Children Die?

Child Deaths - Ages 1-14



National SAFE KIDS Campaign

STATEMENT

BY

MARK ROSENBERG, M.D., M.P.P.

Good morning, Mr. Chairman and Members of the Subcommittee. My name is Mark Rosenberg. I am the Director of the National Center for Injury Prevention and Control at the Centers for Disease Control and Prevention (CDC). I am pleased to be joining with the National SAFE KIDS Campaign and others today to highlight the importance of injury prevention. The National SAFE KIDS Campaign has been in the forefront of the grassroots effort to prevent childhood injuries. SAFE KIDS has developed a successful prototype for all communities to use in preventing the leading causes of injuries to children. I have seen these efforts first hand in my home state, Georgia. Both the State and local SAFE KIDS coalitions in Georgia have been active in promoting child passenger safety, fire and burn prevention, and play ground and bicycle safety to name a few, and were instrumental in the passage of one of the few State-wide bicycle helmet laws in the country.

Introduction

The National SAFE KIDS Campaign is a key player in the overall effort to prevent injuries in the United States. Other partners, including government, non-governmental organizations, academia, foundations, and community-based organizations, perform an important function and help make injury prevention a priority. Without the efforts of both public and private sectors, injuries will continue to cause the death and disability of thousands of children each year. Several key messages will be conveyed in today's hearing. First, injury prevention saves lives and health care dollars. For example, a CDC-supported program in Oklahoma to provide smoke detectors to households showed that for every dollar spent, $20 was saved due to averting fires, preventing hospitalized injuries and burn fatalities. Second, the Federal Government has an important role to play in preventing injuries

overall, especially among children. As you have heard from Dr. Koop and the children who testified, we have come far in this field and know how to prevent many of the injuries to children. As highlighted in the SAFE KIDS report, these intervention methods are inexpensive to implement and have a huge return on investment. As you will hear from Dr. Miller, injuries to children are costly and interventions to prevent them are not. I will focus my remarks today on CDC's contribution to the partnership of injury prevention and control, and provide you a description of CDC's program and a summary of future plans in this area.

Injuries are no accident!

Each year, injuries, identified by the National Academy of Sciences in 1985 as the principal public health problem in America, cause approximately 148,000 deaths, one in eight short-term care hospital admissions, and more than 80,000 permanently disabling conditions. The injury toll on the young is devastating -- it causes more deaths among children ages 1 to 19 years. Injuries cause more deaths than all diseases combined and are a leading cause of disability. Injuries destroy the health, lives, and livelihoods of millions of people. Injuries used to be referred to as "accidents" because they occur suddenly and are seen as unpredictable and uncontrollable. The use of the word "accident" can lead to passive acceptance of injuries as just a fact of life. Injury prevention in children is not just possible, it should be expected.

In 1991, the most recent year for which we have data, more than 21,000 children aged 1 to 19 years died of injuries in the United States. These injuries included deaths from motor vehicle crashes, homicides, suicides, drownings, fires and burns, and poisonings. Each year, an estimated 600,000 children are hospitalized for injuries, and almost 16 million children are seen in emergency departments for their injuries. It is estimated that more than 50,000 children suffer permanent disabilities from injuries each year. The effects of such

disabilities on children's development, daily living, and future productivity are great. Injuries, like disease, occur in highly predictable patterns and if we understand these patterns, we can prevent those injuries. Let me repeat: among children 1-19 years old, injuries cause more deaths than all diseases combined. The National Center for Injury Prevention and Control is a major cause of childhood morbidity, mortality, health care costs and loss of human potential. Injury is a high-priority problem in the United States. The National Academy of Sciences, in *Injury in America* stated the need for a "single coordinated focus of activity that would give visibility to this important public health issue and permit an organized program of effective action to address the problems" and recommended the establishment of a Center for Injury Prevention and Control at CDC. Injury, childhood injury in particular, is an important public health priority and CDC has established its newest Center to investigate ways to prevent and control injuries. The goal of the National Center for Injury Prevention and Control (NCIPC) is to improve the health of Americans by preventing premature death and disability caused by nonoccupational injuries and reduce the human suffering and medical costs associated with these injuries. CDC plays a unique role in injury prevention and control by providing leadership to the injury control community and developing a strong science base to prevent injuries, and by applying outcome-oriented, prevention-focused, applied research to the practical problems at hand.

Leadership

Because injuries are preventable, a planned and coordinated injury control program has the potential to save thousands of lives, prevent a vast number of nonfatal injuries, and measurably reduce the health care costs resulting from injuries. CDC is the focal point for leadership and coordination of injury control efforts in the Federal Government and the nation. The creation of the Center in 1992 was testimony to the Department of Health and Human Service's commitment to preventing and controlling injuries and to the injury control community's support for

leadership at the Federal level. NCIPC provides leadership to the national injury prevention and control community. In the Federal government, CDC has important partners in childhood injury prevention. The Health Resources and Services Administration (HRSA) is providing critical childhood injury prevention services through the Maternal and Child Health Block Grants, which help to fund activities of the Children's Safety Network and demonstration grants for emergency medical services for children. The National Highway Traffic Safety Administration has saved thousands of lives over the past several decades by providing funding to States for programs to reduce traffic crashes, fatalities and injuries. The Consumer Product Safety Commission collects and acts on information on consumer products causing injuries. The Departments of Justice, Labor, Education, Health and Human Services, Housing and Urban Development, Agriculture and Treasury, have recently teamed up to combat violence, to stop the epidemic of children killing children.

CDC has also provided national injury control leadership by 1) creating eight centers of excellence in injury control research at leading universities, 2) promoting a national research program which has supported more than 140 individual research projects and contributed to over 600 scientific publications, 3) supporting more than 28 State health department-based injury control programs, 4) developing a plan which is the basis for the nation's long-term injury control plan, and 5) establishing violence as a major public health issue with a special focus on youth violence against women. A review of CDC's program by the National Academy of Sciences concluded that "the value of the program has been established beyond expectation: researchers have suggested innovative projects far in excess of research resources, educators have introduced new courses in graduate schools, public health programs have sprung to life in state and local health departments across the country, and morbidity and mortality rates are beginning to decline for many categories of injury."

Science-based prevention and control

To reach the goal of preventing premature death and disability caused by injuries, CDC's approach includes methods used to combat traditional public health scourges such as smallpox, sexually transmitted diseases and tuberculosis. We ask four questions about injuries: 1) What is the problem? 2) What is the cause? 3) What works to prevent it? 4) How do you do it? CDC conducts surveillance to monitor trends in deaths, disability, and costs associated with injury, supports research to develop and evaluate strategies to prevent and control injuries, and helps States and communities develop, implement and evaluate effective injury control programs. CDC also supports biomechanics research -- one of the most powerful countermeasures for preventing injury available to us. To describe how these activities have an impact on childhood injury prevention, I will provide you with key achievements of our program relating to children.

What is the problem?

CDC provides expertise and support for the surveillance of injuries. To enable State and local health departments to obtain an accurate picture of their childhood injury problem, CDC funds the development of injury surveillance systems in health departments through 15 capacity-building and 5 surveillance grants. The surveillance-focused grants in State health departments collect data on several types of injuries including head and spinal cord injuries, and injuries from violence. CDC also funded a study to investigate severe injuries among children in Central Harlem. The results of this study show the usefulness of injury surveillance both for guiding the development of a community-based injury prevention program and for evaluating the impact of this program. CDC has also established spinal cord injury as the first reportable noninfectious, nonoccupational condition in CDC's National Notifiable Disease Reporting System. Spinal cord injuries occurring from motor vehicle crashes, and falls, for instance, are a major cause of death and disability for young people.

What is the cause of the problem and what works to prevent it?

Investigating what causes injuries and who is at risk is a critical component of CDC's approach. Research supported and conducted by CDC has advanced the prevention and control of injuries to children. For example, CDC funded research to examine differences in injury rates among Hispanic and non-Hispanic children in California found that rate of pedestrian injury was higher in the Hispanic population studied. The goal of the study is to implement and evaluate a program to prevent pedestrian injuries among these children. Other studies showed that children are at greatest risk for bicycle-related head injury and that helmets reduce the risk of nonfatal injury by 85 percent. Evaluation of a community-wide educational program in Seattle increased helmet use from 6 percent to 38 percent and a mandatory helmet use law in Howard County, Maryland increased helmet use from 4 percent to 47 percent. CDC also supports research to evaluate what works to prevent violence among youth and adolescents.

How do we prevent injuries to children?

State and local health departments deliver injury prevention programs and assist communities in devising programs specific to their needs. CDC provides support, both financial and technical, to State and local health departments to develop injury control programs and implement interventions. The CDC injury control program has contributed to the development of more than 38 State health department-based injury control programs through 15 State and community-based grants. CDC's financial support of these programs is critical. Many of these programs could not have started without assistance from CDC. Specific programs run by the injury control programs in these States include bicycle helmet programs, pedestrian safety, child safety seat promotion, poison prevention, violence prevention, smoke detector promotion, and drowning prevention. Some notable accomplishments in these state programs include the promotion and use of bicycle helmets in Maryland, New York and Oklahoma; the development of farm safety curricula in North Dakot[illegible]ich is used in over 43

counties in the State; the screening of 1,000 households with children under 6 in Rhode Island for lead poisoning and smoke detector use; and the training of over 5,800 individuals in drowning prevention in Alaska. An evaluation of the effectiveness of the program in Alaska documented 21 lives saved. Drowning prevention was also a major focus of an injury prevention program in Florida. The program reported a decrease in pediatric admissions due to submersion incidents at two hospitals.

Future plans and conclusion

CDC's efforts in the area of childhood injury prevention will continue to be a high priority. In the future, CDC plans to continue work with partners like SAFE KIDS to help close the gap for injury morbidity and mortality rates between children of low socioeconomic status and those of middle and upper socioeconomic status. Effective countermeasures are available to prevent each type of injury, and studies have documented their enormous potential to save lives and reduce medical care costs. However, these countermeasures are used far less in communities of low socioeconomic status than in more affluent areas. Furthermore promoting the use of injury countermeasures through injury control programs, and public education will benefit all children.

In conclusion, CDC plays an important role in preventing injuries to children by providing leadership and developing a strong science base to promote research and programs to prevent and control injuries. The partnership between the public and private sectors will continue to be strong and help make injury prevention, including injuries to children, a priority for the nation.

Written Testimony of Ted Miller, Senate Subcommittee on Children, Family, Drugs and Alcoholism, Preventing Childhood Injuries Produces Documented Cost Savings, 5/10/94

I am an internationally recognized safety economist. I direct the Children's Safety Network Economics and Insurance Resource Center and the Safety and Health Policy Program at the National Public Services Research Institute (NPSRI). NPSRI and its parent organization, the Pacific Institute for Research and Evaluation, are nonprofit organizations that specialize in research and policy analysis on substance abuse, unintentional injury, and violence. The Children's Safety Network is a group of six resource centers funded by the Maternal and Child Health Bureau in DHHS. The Network fosters development and inclusion of childhood injury and violence prevention strategies into maternal and child health services, organizations, and programs. Our Center, which includes the National SAFE KIDS Campaign, works to forge child safety partnerships with third party payers. It also informs the public and decision-makers about safety economics.

My testimony today represents solely my own views and estimates. It is not the official position of my funders or my employer.

My testimony is divided into three sections. They describe:

- Injury's share of child medical care spending
- The medical cost savings of selected injury prevention efforts.
- Steps we can take to improve child safety.

All dollar estimates in my testimony are stated in November 1992 dollars.

Injury's Share of Child Medical Care Spending

Injury is widely known to be the leading cause of death at every age from 1 to 45 (Rice, MacKenzie, 1989). From age 0 to 21, aggregate medical spending on injury exceeds medical spending on any other health care condition except live birth (Miller, Lestina, and Galbraith, 1994). That conclusion comes from recently released 1987 National Medical Expenditure Survey (NMES) data. Our analysis includes spending on hospital inpatient, outpatient, and emergency room care, physician and allied health professional services, prescriptions, emergency transport, medical supplies and equipment, including eyeglasses, and insurance claims processing costs. It excludes $15 billion in birth-related costs, as well as dental and nursing home costs.

Assuming the 1987 spending pattern is accurate[1], for children under age 15, we estimate injuries caused $5 billion of the $42 billion in 1992 medical spending for services that we studied. That's about 12 percent.

In 1992, medical spending on injury treatment averaged about $100 per child (based on the 1987 distribution of costs). But medical care costs are not the only public costs imposed by injury. Annually, more than 50,000 children are injured so severely that they permanently lose some capacity to work (Miller, Pindus, et al., 1994). That creates Social Security disability costs and home health services costs. It disrupts parents' workplaces and drains society of productive labor.

Medical Cost Savings of Injury Prevention

Health care reform should stress injury prevention.

Why? First, because we have a responsibility to care for our children and injury is the leading cause of child death from age 1 onwards. Second, out of compassion for children whose parents cannot afford things like child seats and cabinet locks. Third, to save money.

Preventing injuries is cheaper than patching them. Table 1 gives 5 examples. All have extremely large benefit-cost ratios, ranging from 10 to 70.

Definitions and Methods. Table 1 includes three categories of costs. The first category is **medical spending**, including spending on emergency medical services, hospital and physician care, rehabilitation, prescriptions, and medical claims processing. The remaining two categories -- other tangible costs and quality of life -- collectively are called **other social costs.**

[1]Two things may have changed the pattern of medical spending between 1987 and 1992 -- AIDS and improving medical technology which causes illnesses and injuries that once were quickly fatal to become costly and protracted but survivable episodes.

The other tangible cost category includes work that children will not do in the future if they are killed or permanently disabled. These productivity losses hurt our economy and put people with disabilities on public assistance. Our auto insurance often pays for productivity losses caused by auto crashes, as well as for legal expenses involved in compensating these losses. Other tangible expenses also include police and fire services required to deal with crash injuries, and property loss and associated insurance claims processing costs avoided by smoke detectors. My estimates of lost productivity are conservative -- they exclude costs to families and employers when parents miss work to care for injured children.

The quality of life category places a dollar value on the pain, suffering, and lost quality of life that results from injury. To value these losses, we used a large literature that analyzes what people actually pay on a daily basis for small changes in their risk of being killed. This literature answers questions like how much people spend for car safety feature or how they trade off travel time and safety when choosing how fast to drive during a rainstorm. The U.S. Office of Management and Budget (1989) requires Federal regulatory analysts to use this method when they analyze safety issues. Miller (1990) reviews this literature and derives a conservative estimates for the value of saving a life. The value includes the productivity loss plus the quality of life loss.

To value preventing nonfatal injuries, we started from physician ratings of the typical effects of different injuries on functional capacity in six categories: cognitive, mobility, bending and lifting, sensory, cosmetic, and pain. We added data on the probability that each injury would cause permanent disability. Using survey data that described how people rate different functional losses relative to one another and to death, we converted the functional losses into a percentage loss in life value. Multiplying the percentage loss times the quality of life lost to a fatality yields the loss for injury.

For selected injuries, we validated the quality of life loss estimates against more than 1,000 jury awards for pain and suffering due to nonfatal injury. The average varied by less than 5 percent, although the discrepancies were much larger for some injuries. Our estimates of quality of life lost to injury are used in regulatory analysis by the U.S. Department of Transportation and many state transportation departments. They have passed peer review repeatedly (e.g., Miller, 1993; Miller, Cohen, and Rossman, 1993; Miller, Douglass, and Pindus, 1994).

Cost-Benefit Analyses. Safety efforts can control health care costs. We have many proven approaches. With adequate research funding, we could readily find more among the many seemingly effective measures already in use.

Table 1 describes the estimated costs and benefits of five typical safety interventions as follows:

- Bicycle helmets. Including distribution and fitting, we can put helmets on children for $13 to $15. Each helmet prevents $30 in medical spending. It also saves lives and prevents permanent disabilities, saving over $400 in other social costs (Miller and Galbraith, 1993).

  Remember, some of the social cost savings are real dollars. Our auto insurance, our fire insurance, our economy all help pay the bill. For example, this bicycle helmet saves auto insurers $12.

- Poison control centers offer returns comparable to immunizations. Every $10,000 invested in poison control saves more than $75,000 in medical spending. Yet health insurers do not pay these centers for the services they deliver (Miller, 1994).

- Smoke detectors cost $12 to $18 installed. They offer savings of $18 in medical spending and $1,225 in other social costs. This benefit-cost ratio was done for this hearing and is preliminary. It uses the burn injury costs from Miller, Brigham, et al. (1993). It is consistent with as yet unpublished work by the National Center for Injury Prevention and Control at CDCP that finds the ratio of tangible smoke detector benefits to costs is 20:1.

- Child safety seats. The cost is $40 for a convertible seat that a child can use through age 4. Each seat saves taxpayers $80 in medical expenses and $1,200 in other social costs (Miller, Demes, and Bovbjerg, 1993).

- **Injury prevention counseling by pediatricians.** The American Academy of Pediatrics has a program called TIPP, which stands for The Injury Prevention Program. For children under age 5, TIPP recommends counseling at 11 well-care visits. The counseling costs about $70. It saves at least $60 in medical spending and $580 in other social costs (Miller and Galbraith, 1994).

Steps We Can Take to Improve Child Safety

More safety efforts need to be built into our health care system, both now and under health care reform. Our Medicaid bills would be lower today if Medicaid or Aid for Families with Dependent Children (AFDC) bought safety devices for indigent children.

Let's again use the 5 safety measures as examples. Table 2 shows the cost savings if taxpayers funded those measures for Medicaid recipients under age 15.

The net medical care cost savings are $130 million annually, about 2 percent of Medicaid spending on children. In addition, we would preserve future productivity for our economy and improve the quality of life of children and families. These added benefits are valued at $3.75 billion annually.

Some states know these savings are available and want to realize them if the Federal government will pay its share. With Federal match, AFDC programs in North Dakota and Minnesota pay for child safety seats today. Without Federal match, Virginia gives a convertible child safety seat to each baby on Medicaid. New Mexico and Washington state both have sought Federal permission to cover child safety seats through Medicaid. Ohio has an extensive seat distribution program, and Georgia is exploring a possible AFDC program.

As a cost control measure, I believe that Medicaid should be modified now to authorize Federal match for states that choose to cover the bulk purchase and distribution cost for child safety devices that offer proven net medical cost savings. An income eligibility cap or sliding fee scale might be a sensible control on this provision. Every day we wait, we waste money while children die.

Health insurers, health care reformers, and the burgeoning managed care systems also need to promote safety. Payers and gatekeepers can employ a combination of beneficiary incentives and sanctions, plus provider controls. For example, I estimate that health and auto insurers can save money by training volunteer fire departments to check that child seats are installed correctly or by funding sobriety checkpoint blitzes (which could help to prevent the 25 percent of child motor vehicle deaths that are attributable to drunk driving).[2] Health insurers can encourage employers to give employees child seats as baby presents and bicycle helmets as incentives for adhering to well-care visit schedules. They can encourage injury prevention counseling in compensable well-care visits and ask doctors to distribute "prescription forms" for safety devices at bulk purchase prices. They can require hospitals to code injury causes in their discharge records and pressure states to establish hospital discharge reporting systems. They can compensate poison control centers for services rendered to policyholders.

Congress needs to assure that safety plays a strong role in health services research and public health infrastructure under health care reform. Research fund allocation decisions should consider the order of magnitude of medical spending and life years lost from specific health problems. State health departments should have injury prevention units. And discretionary Federal health care funds should include injury prevention and control as an eligible expenditure.

Legislative mandates to use safety devices also are desirable. Most people want to be good parents. Laws have proven highly effective tools to help them to protect their children. Laws also help parents to convince their children to use safety devices.

Child safety. It's our responsibility, morally and fiscally.

[2]Auto insurers currently are helping to pay for these activities in a North Carolina demonstration program.

Table 1. Costs and Benefits of Five Child Safety Measures (in 11/92 dollars)

	Cost	Medical Cost Savings	Other Tangible Savings	Quality of Life Savings	Benefit Cost Ratio
Bicycle Helmets	$15	$30	$107	$293	29
Child Seats	40	72	236	960	32
Smoke Detectors	18	18	248	976	69
Poison Control Centers	27	209	?	?	8+
Injury Counseling by Pediatricians	68	61	122	483	10

Note: ? = dollar value of savings unknown. Smoke detector costs include $10 for installation and maintenance. The smoke detector analysis is preliminary.

Table 2. Annual Costs and Return on Investment in Typical Safety Measures for Children on Medicaid (M = millions of 11/92 dollars)

	Medicaid Cost	Medicaid Savings	Other Social Cost Savings
Bicycle Helmets	$10 M	$20 M	$255 M
Child Seats	25 M	45 M	765 M
Smoke Detectors	10 M	10 M	785 M
Poison Control Centers	10 M	135 M	?
Injury Counseling by Pediatricians	220 M	195 M	1,935 M
TOTAL	$275 M	$405 M	3,740 M

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Information About Youth Violence Requested from Ted Miller, 5/10/94 Dodd Hearing

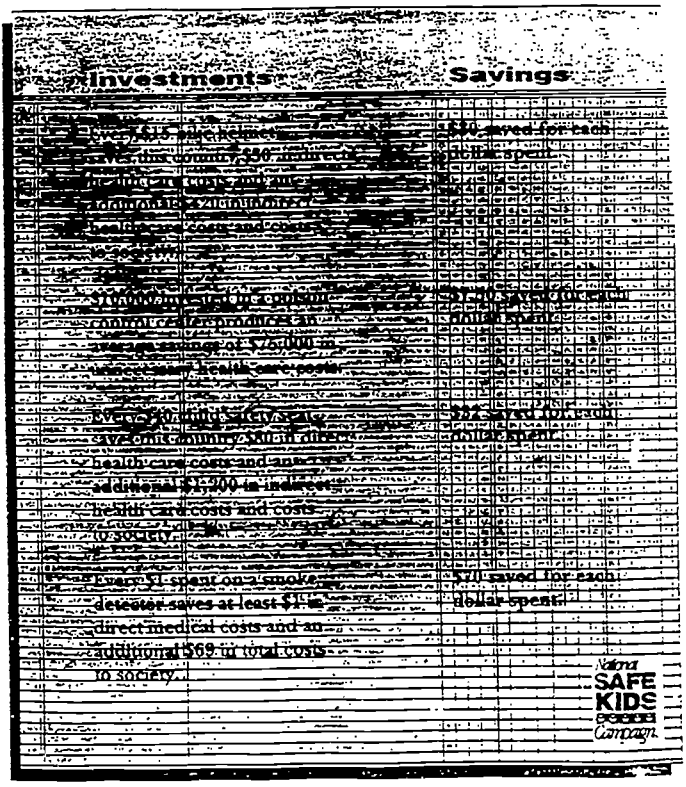
The data I have on youth violence are about crimes committed against children, not crimes committed by children. Children under age 18 are the victims of at least 7 million personal crimes annually. These crimes include murder, child abuse and neglect, rape, robbery, assault, and arson-related injury. The monetary costs of these crimes exceed $19 billion, including almost $5 billion in medical and mental health care spending and $14 billion in lost future productivity and government services. In addition, drunk drivers violently victimize more than 300,000 children annually, imposing another $3 billion in tangible costs. The greatest impact of violence against children, however, is the pain, suffering, and lost quality of life facing victims and their families. Preliminarily, my team estimates these losses might be valued at 5 to 10 times the monetary losses.

The cost estimates for child abuse and neglect are probably incomplete. They do not fully capture the effects of these crimes. Repeated victimization can shatter lives, leaving victims unable to earn a decent living. It also can twist morality; victims disproportionately become violent offenders. Cathy Spatz-Widom, in a 1993 National Institute of Justice REport (The Cycle of Violence) estimates abused and neglected children are 1.4 times as likely to commit violent acts as other children. The estimated maltreatment rates in this study, thus, imply that 13 percent of all violence results from prior abuse. The costs of these induced crimes, including the incarceration costs, could properly be added to costs of the original abuse. Doing so would substantially raise the costs of child violence.

These estimates come from an ongoing study for the National Institute of Justice.

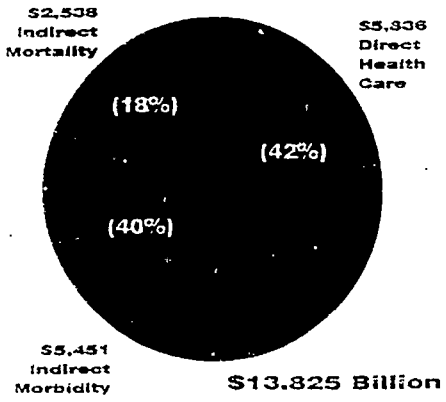
Injury Prevention:

It Works and Saves Money



Annual Lifetime Cost of Injury for Children Birth - Age 14

(in millions of dollars)



$13.825 Billion

SAFE KIDS

Annual Costs and Return on Investment in Injury Prevention for Children on Medicaid

	Medicaid Cost	Medicaid Savings	Other Social Cost Savings
	($ in Millions)		
Bikehelmets	$70	$320	$256
Child Restraints	$28	$48	$785
Smoke Detectors	$10	$10	$785
Poison Control Centers	$10	$135	
Injury Prevention Counseling by Pediatricians	$220	$196	$1,938
TOTAL	$275	$405	$3,740

SAFE KIDS

TESTIMONY OF
HELEN HALPIN SCHAUFFLER, Ph.D., M.S.P.H.

Good morning Senator Dodd and other distinguished members of the subcommittee. It is an honor and my pleasure to be here this morning to discuss with you some of the key issues that must be addressed in health care reform if we are to reduce childhood injury in the United States.

I am Dr. Helen Halpin Schauffler. I am presently an Assistant Professor of Health Policy and the King Sweesy and Robert Womack Chair in Medical Research and Public Health at the University of California at Berkeley, School of Public Health. Prior to coming to the University of California, I worked in the Massachusetts Department of Public Health, directing the state's community-based prevention programs and I chaired the Boston Regional Health Promotion Council. For four years I was also a lecturer in health policy at the Harvard School of Public Health. I recently co-authored a report that was funded by The California Wellness Foundation entitled, "Health Promotion and Disease Prevention in Health Care Reform." The report makes specific legislative recommendations for incorporating health promotion and disease prevention into health care reform. All of the members of this subcommittee should have received copies of this report when I testified before the full committee last November. More recently, on behalf of the Partnership for Prevention, I drafted model legislative language for prevention that can be incorporated into any health care reform bill at any stage of the legislative process. I would like to introduce copies of both of these reports into the record this morning, along with my written testimony. My goal in preparing these reports, and in testifying before you, is to make promoting the health of the American people, and specifically promoting the health of America's children, an explicit goal of health care reform.

I have both professional and personal motivations in pursuing this goal. Like the children who have come here today to share their stories with you, I too have been personally touched by childhood injury. As a three year old, I was fooling around with the back door of my mother's car as we were traveling 35 mph down a city street in Ohio, when I inadvertently opened the back door, fell out of the car and landed on the pavement, sustaining a head injury that required multiple stitches all over the top of my head. I was fortunate that the injury was not disabling (although my friends often suggest that this incident may explain many things about my personality!) My younger brother, Eric, however was not as fortunate. As a teenager, Eric was driving home late one night from his girlfriend's house when he had a terrible car crash. He was thrown from the car, as he was not wearing his seatbelt, and Eric died. My family and I know first hand the tragedy of preventable childhood injury.

The Administration and Congress are presently engaged in an important debate over how to reform the U.S. health care system, and by that I mean not just the medical care system, but also the public health system. Health care reform provides us with an important vehicle to achieve the goals set out for us this morning by the other members of this panel and by Dr. Koop. I feel confident in saying that all of the health care reform bills that have been introduced in the Congress need to be considerably strengthened with respect to their provisions for funding, incentives, and coverage of services that will contribute to reducing childhood injuries in the United States.

A relatively few dollars spent now on programs that help to reduce and/or prevent unintentional injuries will certainly save many more dollars in the future. In fact, taking a few simple, cost-effective steps by investing in childhood injury prevention can potentially save the health care system billions of dollars. The report introduced into the record by the National SAFE KIDS Campaign today outlines the statistics that demonstrate that preventing childhood injuries can produce real, documented health care savings.

Specifically, however, I want to focus on three areas this morning that require your immediate attention as you begin deliberations and discussions over what should be included in a comprehensive health care reform bill. These three areas address provisions to increase accountability for childhood injury prevention, provisions to adopt comprehensive public policy for childhood injury prevention, and provisions to increase support for population-based programs for childhood injury prevention.

Accountability: The first area that needs to be addressed is accountability for childhood injury prevention in health care reform. We need to make reducing childhood injury an explicit goal of health care reform, and hold every part of the health care system -- health plans, state and local health departments, and community-based programs -- accountable for doing all that is required to reduce childhood injury.

To begin with, uniform measures of childhood injury need to be established at the federal level, as part of the development of a comprehensive set of national performance measures. Population-based state and community-level information about specific injury problems is needed to develop and evaluate prevention strategies and to set priorities. Health care reform must mandate adoption of a standardized system for the definition and classification of injuries that is accurate, efficient and compatible with the ICD injury classification system, and the ICD Supplemental Classification of External Causes of Injury and Poisoning (E-Codes).

These measures should include the incidence of nonfatal and fatal unintentional childhood injuries (for example, injuries due to scald burns, drowning, residential fires, poisoning, motor vehicle crashes, bicycle injuries, head injuries, spinal cord injuries, etc.).

Uniform measures are also needed on the prevalence of specific risk factors associated with preventable childhood injuries, such as rates of use of occupant protection systems, including child safety seats and seat belts, and use of other protective devices, including bicycle helmets, smoke detectors in homes, etc. Health care reform must mandate the development and implementation of uniform risk factor surveys to be used at the federal, state and community levels.

Uniform measures are also needed to promote age-appropriate counseling to prevent childhood injuries by primary care providers. Health plans and primary care providers must be held accountable for routinely providing counseling to children and their parents on safety precautions to prevent unintentional childhood injury. Some health plans are even experimenting with tieing payment levels to performance on providing appropriate preventive care. Our health care system has a long way to go to meet this expectation. According to a survey recently commissioned by the SAFE KIDS Campaign, nearly 60 of parents reported that they had never been counseled by their child's physician about injury prevention.

Responsibility for collecting and reporting uniform data should be given to the state and local health departments. One organization must be held responsible for integrating and summarizing the data provided by a myriad of sources. Relevant data are collected by health departments, hospitals, health plans, emergency medical and ambulance services, trauma registries, law enforcement, transportation, and fire safety agencies, and many others. Uniform population-based measures of childhood injuries will enable this integration, making possible the ability to conduct a comprehensive population-based assessment, and to measure progress towards achieving our goals. Health care reform should require state health departments to set measurable objectives to reduce unintentional childhood injuries, and the Federal government should hold states accountable for making progress towards these goals. At a minimum states should be expected to meet the goals established in Healthy People 2000.

Public Policy: As we have heard this morning, one of the most effective and efficient means of reducing childhood injuries is through the adoption of public policies that mandate specific safety precautions. These policies include mandatory bicycle helmet laws, mandatory safety belt and child safety seat laws, building codes addressing the installation of smoke detectors and fire suppression sprinkler systems, plumbing codes that mandate installation of anti-scald plumbing valves, laws mandating four-sided fencing around public and residential swimming pools, and laws mandating academic instruction on injury prevention and control as part of comprehensive school health education in the public schools. While many states have enacted legislation and adopted regulations addressing some of these areas, many others have not.

For example, nine states still do not have mandatory smoke detector laws; 22 states have not adopted scald burn prevention language in building codes; 40 states have not enacted mandatory bike-helmet laws; and while child occupant protection laws have been adopted by all 50 states, these laws vary widely in their age requirements, exemptions, enforcement procedures, and penalties.

States must be held accountable for adopting comprehensive public policies that have been demonstrated to be effective in reducing unintentional childhood injury, and state health departments must be held accountable for working with other governmental agencies including law enforcement, transportation, and fire, to monitor and enforce these laws. One mechanism for accomplishing these goals is for the federal government to tie other, related sources of federal funding, such as transportation, housing or public health funding, to a state's enactment of specific legislation. This approach proved to be extremely effective in achieving uniform state adoption of the 55 mph speed limit laws and raising the legal drinking age. A goal of health care reform should be that all 50 states implement comprehensive child safety legislation.

Support for Public Health and Community-Based Programs: In discussing the importance of both accountability and public policy, I have mentioned the important role our public health departments must play in collecting, analyzing and reporting data, taking the lead in developing public policy, and integrating and coordinating the activities of other governmental agencies that have an important role to play in monitoring and enforcing public policy to prevent childhood injury. Unfortunately, our public health system is presently in disarray. The public health system has become the provider of last resort for the large and growing number of persons without health insurance in our country. As a result, only a fraction of the resources going to public health are spent on population based prevention programs, and instead go to pay for emergency and acute medical care for underserved populations.

Presently, less than 1% of total health expenditures goes to fund population-based prevention programs, and this meager percentage has been shrinking over time. The Department of Health and Human Services has estimated that funding levels equal to at least 3% of total health care expenditures or approximately $100 per capita are needed to support a fully effective public health system. It is essential that health care reform provide for stable and adequate funding for public health.

In addition, federal funding is needed to support the development and implementation of community-based childhood injury prevention programs. For example federal funding priorities should include support for development and maintenance of community-based poison control centers, programs that subsidize the costs of child safety devices for low-income families, and support for injury prevention units in state and local health departments so that they can provide technical assistance and funds to stimulate local community efforts to develop the broad based coalitions required to address childhood injury prevention at the community level.

It simply will not be possible to achieve the goals of childhood injury prevention without an effective public health system and funding for community-based injury prevention programs. While the medical care system has an important role to play in providing individual counseling for childhood injury prevention, its role is limited compared to the impact of public policies and the coordinated efforts of communities. Reducing unintentional childhood injury requires the involvement and combined efforts of many different sectors of society including public health, education, business, medical care, transportation, law, engineering, architecture and the safety sciences. It is only at the community level, through public education efforts, local monitoring and enforcement of laws and regulations, and public participation that we will realize our goals of reducing unintentional childhood injuries.

Our nation's children are at risk. The leading cause of death and disability is unintentional injury. We have heard described this morning the many policies and programs that have demonstrated their effectiveness in reducing childhood injury, not only in preventing pain, suffering and loss of life, but also reducing the expenditure of associated medical care costs and other costs and burdens to society. I urge you to seize the opportunity before you as you debate and pass health care reform legislation to increase access to effective injury prevention programs and resources, and seek to protect all children, regardless of what state or community they live in, against unintentional injury. I believe that we can achieve this goal if we make it explicit within the context of health care reform and build into health care reform the necessary support, incentives and systems of accountability to make it a reality.

The children here today are evidence and support that childhood injury prevention must be an integral component of health care reform. The burden is on many, including this committee, to protect future generations of children from death and injury and to save billions of health care dollars which are now being spent on injuries that never ought to have happened.

I would be happy to answer any questions from the subcommittee. Thank you.

Health Promotion and Disease Prevention in Health Care Reform

EXECUTIVE SUMMARY

Contract Report to

THE CALIFORNIA WELLNESS FOUNDATION

PRINCIPAL INVESTIGATOR

Helen Halpin Schauffler, Ph.D., M.S.P.H.

PREVENTION IN HEALTH CARE REFORM ADVISORY GROUP

The Prevention in Health Care Reform Advisory Group was created by The California Wellness Foundation to provide guidance and direction in developing a model and recommendations for action to incorporate health promotion and disease prevention in health care reform. The Advisory Group represents expertise from academia (public health and medicine), managed health care plans, community-based health services, local public health departments, and employers. The Advisory Group met once at the beginning of the project on June 30, 1993 to identify the set of key issues to be addressed in the development of a comprehensive model for health promotion and disease prevention in health care reform, and to identify resources and materials that contributed to this effort. The Advisory Group reviewed the draft report and met a second time on September 27, 1993 to revise the recommendations. The Advisory Group reviewed and approved the final report in October, 1993.

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We also wish to thank the following persons for reviewing the draft recommendations and for their helpful and insightful comments and suggestions: Barbara Abrams, Daniel Fox, Carol D'Onofrio, Ralph Paffenbarger, James C. Robinson, and Lawrence Wallack.

We are also grateful to The California Wellness Foundation for providing the funding for this project and for the publication of this report. The California Wellness Foundation is an independent, private foundation founded in 1992 to improve the health of the people of California.

EXECUTIVE SUMMARY

Improving the health of the American people must be a central goal of health care reform. Health care reform that increases access to health care and controls health care costs will stop short of achieving real health security if it fails to improve the public's health. Clear incentives for improving health status, as well as accountability for demonstrating positive health outcomes, are needed in every part of the system. At each level — national, state, local, health plan, health department, community organization, health care provider, and individual — our shared objective must be to reduce risk for disease and maintain and improve the health status of our population.

The major determinants of the leading causes of disease and disability in the United States are environmental (physical, social and economic) and behavioral (tobacco use, diet and nutrition, physical activity, sexual behavior, alcohol and drug use, unintentional injury, and violence). The medical care system is limited in what it can do to control and reduce these major risk factors. Instead, these problems need to be addressed at the community and societal levels. Schools, community clinics, churches, employers, labor unions, government, public health departments, voluntary organizations, advocacy groups, social support groups, and formal and informal communication networks, to name just a few, need to work together in a coordinated and integrated approach to improve the public's health.

Health must be viewed as a continuum, from complete physical, social and mental well-being at one extreme (the goal of health promotion) to illness, disability and death at the other (the targets of prevention.) We have a different level of understanding regarding the underlying causes of every disease, injury and disability and how it moves along the health continuum. The aim of health promotion and disease prevention is to intervene as early in the process as possible and, to the extent that our knowledge allows, prevent disease and disability entirely. Our recommendations provide a comprehensive framework for incorporating health promotion and disease prevention into a reformed health care system.

Public health and preventive medicine organizations have mobilized to assure that health c. e reform addresses prevention and public health. A non-profit organization, Partnership for Prevention, founded in 1991 to increase prevention's priority in national policy and practice, outlined the essential principles of prevention in their 1993 paper, "Prevention is Basic to Health Care Reform." Our recommendations are organized around the three essential elements of prevention outlined in that document:

- PUBLIC POLICY FOR HEALTH PROMOTION AND DISEASE PREVENTION;
- COMMUNITY-BASED HEALTH PROMOTION AND DISEASE PREVENTION; and
- CLINICAL PREVENTIVE SERVICES.

Our specific objectives in making these recommendations are to:

- implement an integrated model of health promotion and disease prevention that coordinates the prevention efforts and information systems of health plans, community-based organizations, public health agencies and government to attain the goals set forth in Healthy People 2000: Health Objectives for the Nation;
- adopt comprehensive public policy for prevention at the federal, state and local levels;
- increase the availability and effectiveness of community-based health promotion and disease prevention; and
- increase appropriate use of clinical preventive services for all Americans.

ROLE OF GOVERNMENT IN PROMOTING HEALTH AND PREVENTING DISEASE

The model for health promotion and disease prevention we recommend seeks to strengthen and coordinate the efforts of all of the individuals and organizations (public and private) involved in health promotion and disease prevention. Our model does not try to micro-manage the health care system, but instead leaves decisions regarding the specific methods used to achieve the goals of health promotion and disease prevention to the states, health alliances, health plans, public health and community-based organizations, and health care providers.

The role of government in this model is to set national priorities and define goals, standards and systems of accountability for measuring and monitoring system performance. Specifically, we envision government involvement in health promotion and disease prevention to include the following:

- Government provides the link between the science of prevention, policy for prevention and the practice of prevention within the context of health care reform.

- Government has a role in establishing national goals for health promotion and disease prevention, implementing public policy to accomplish those goals, and supporting an integrated and coordinated approach to health promotion and disease prevention at the national, state and local levels.

- Government has a role in defining uniform measures of health status for assessing system performance and for supporting the development of integrated and wholly compatible information systems at all levels in the health care system.

- Government has a role in providing stable and adequate funding to support the core public health functions in state and local health departments, and health promotion programs provided by community organizations.

- Government has a role in increasing the number of health professionals with the skills, competencies and understanding necessary to prevent disease and promote the public's health.

- Government has a role as an entrepreneur in funding new and innovative research to address the enormous gaps in our knowledge of how best to motivate individuals, organizations and communities to engage in health enhancing behaviors.

- Government has a role in disseminating the findings of research in the form of practice guidelines to providers, health plans, communities and states in a timely manner so that the prevention we practice is based on approaches that have been demonstrated to be most effective.

MAJOR LEGISLATIVE RECOMMENDATIONS

I. PUBLIC POLICY FOR HEALTH PROMOTION AND DISEASE PREVENTION

- Require that a designated party at each level of government be responsible for integration and coordination of public policy for health promotion and disease prevention.
- Define clear and appropriate roles and functions of the major health organizations involved in the development and implementation of public policy for health promotion and disease prevention (federal government, state and local health departments, health alliances, health plans and community organizations).
- Require the Department of Health and Human Services, in cooperation with the National Committee for Quality Assurance, to develop uniform measures of health outcomes, risk status, and preventive services utilization.
- Require states, health alliances and health plans to develop integrated data systems within the overall framework of an integrated national health information system.
- Require the party responsible for developing and implementing policy at each level to provide information and data to the level above it on the public policies for prevention that have been adopted and data on the health status of the population using uniform measures established by the federal government.
- Provide federal funding to the Agency for Health Care Policy Research, Department of Health and Human Services to support policy research on the impact of comprehensive, multi-disciplinary approaches to public policy for health promotion and disease prevention.
- Require the Department of Health and Human Services, through the Office of Disease Prevention and Health Promotion, to disseminate the findings from policy analysis and research to encourage adoption of the most effective policies to improve health.
- Support the development of a multi-faceted, multi-disciplinary approach to public policy in all domains affecting health using a variety of public policy tools, including participatory decision making, public education, incentives, taxation, and regulation.

II. COMMUNITY-BASED HEALTH PROMOTION AND DISEASE PREVENTION

- Provide states with federal funds to develop and implement integrating structures at state and local levels to coordinate the prevention activities and information systems of health plans, community-based organizations, health departments and governments, and to increase community participation and collaboration in setting priorities, planning and implementing community based health promotion and disease prevention.
- Provide stable and adequate federal funding to support state and local health departments in providing the core public health functions of policy development and administration, public health education, data collection and analysis, epidemiologic surveillance, assurance of public health services, professional training and education, environmental protection, and laboratory services.
- Provide stable and adequate federal funding through grants to community organizations and local public health departments to support community-based approaches to the nation's high priority health problems. Permit states to consolidate federal categorical grants to address the state's health priorities.
- Provide federal funding for development of continuing education programs to provide training for current primary care practitioners and public health professionals in community health promotion and disease prevention.
- Provide federal funding to health professions schools to develop and incorporate training in community-based health promotion and disease prevention into the educational curricula of

primary care clinicians (including physicians, nurse practitioners, physician assistants and nurse midwives) and public health professionals.

- Increase federal funding to support research and demonstration programs on the effectiveness of different approaches to delivering community-based health promotion and disease prevention interventions.

- Provide funding to evaluate the role of community health workers and their impact on community participation in and utilization of community-based health promotion and disease prevention and their impact on the health of communities.

- Require the Department of Health and Human Services, through the Office of Disease Prevention and Health Promotion, to establish a continuous and rigorous review of the research on community-based health promotion and disease prevention, and disseminate the findings of research to public health and community-based organizations.

III. CLINICAL PREVENTIVE SERVICES

- Include clinical preventive services as a category of health services covered in the minimum standard national health insurance benefit package, but do not specify the individual clinical preventive services covered or their periodicity in legislation.

- Authorize a national, independent scientific body — such as the U.S. Preventive Services Task Force (USPSTF) — to determine the standard, minimum clinical preventive services benefits and their recommended periodicity for coverage. Mandate that this body update their coverage recommendations annually, based on a continuous, rigorous review of the most current scientific evidence on the effectiveness and cost-effectiveness of clinical preventive services.

- Exclude from patient cost sharing (deductibles, coinsurance and copayments) the clinical preventive services covered in the standard minimum benefit package, provided that their use is consistent with any applicable periodicity schedule.

- Require health plans to establish automated data systems, that are wholly compatible with state and national data systems to collect data on preventive services utilization, risk status of the enrollee population, and incidence of preventable health outcomes using uniform measures of performance. Require health plans to provide annual data to the health alliances and state health departments.

- Require health alliances and health plans to set measurable short and long range goals for improving their performance in providing preventive services to their enrolled population, decreasing the prevalence of modifiable risk, and reducing the incidence of preventable health outcomes.

- Require health alliances to monitor health plan progress towards goals and annually publish a summary report of the performance of each health plan offered by the alliance with respect to preventive services utilization, prevalence of risk factors and incidence of preventable health outcomes.

- Change the incentives which influence physician choice of specialty to increase training opportunities and desirability of primary care specialties and to manage the supply of specialists.

- Increase federal funding to train nurse practitioners, certified nurse midwives, and physician assistants, and encourage states to remove licensing and reimbursement barriers that limit the full integration of these health care providers into the health care delivery system.

- Increase federal funding for research on the effectiveness and cost-effectiveness of preventive services, in particular preventive counseling and health education.

- Provide increased federal funding on primary care research and the integration of health promotion and disease prevention into primary care.

- Require the Department of Health and Human Services, through the Office of Disease Prevention and Health Promotion and the National Coordinating Committee on Clinical Preventive Services, to establish a continuous and rigorous review of the most recent research on the effective practice of preventive medicine.
- Require that practice guidelines be developed, summarizing the findings of research and identifying the most effective approaches to overcoming non-financial barriers and increasing appropriate utilization of preventive services.
- Support the widespread dissemination of practice guidelines for clinical preventive services to all health plans and primary health care providers, as appropriate.

SIGNIFICANCE

At present, public policy for prevention is fragmented and fails to make use of the variety of policy tools available to influence health promoting behaviors of individuals and institutions. In addition, the present array of community-based health promotion and disease prevention programs, funded largely through federal categorical grants to state and local public health agencies and community organizations, is likewise fragmented, uncoordinated, and insufficient to improve the health of our communities. Until very recently, most health insurance plans in the U.S. did not cover any preventive screening services, health education or immunizations in their benefit packages. As a result many Americans have not received the clinical preventive services they need, thus contributing to the high levels of preventable morbidity and mortality in the population. Our goal in developing the above recommendations is to address these failures in the present system and move toward a comprehensive and integrated approach to health promotion and disease prevention in health care reform.

Our proposal is broad in its scope. Recognizing that American politics more often produces incremental change, as opposed to broad sweeping reforms, we understand that all of our recommendations may not be addressed in the present effort to reform the U.S. health care system. However, we believe it is important to lay out a comprehensive, long-term vision for health promotion and disease prevention towards which we can work over time. At the very least, we hope that federal and state governments will adequately support the core public health functions and community-based health promotion and that clinical preventive services will be covered under a minimum standard national health insurance benefits package. Our country's efforts to improve the health of all of its citizens is likely to be much more effective if preventive medicine is pursued in partnership with broader based community efforts to promote health and prevent disease, coupled with comprehensive healthy public policy.

Sources: APHA 1993; Breslow 1990; Davis et al. 1992; Fox 1993; Leaf 1993; McGinnis et al 1992; Nelson et al 1981; Osborne and Gaebler 1992; Partnership for Prevention 1993; Rose 1992; Schauffler 1993; Temple and Burkitt 1993; Terris 1990; Tolsma and Koplan 1992; US DHHS 1990; USPSTF 1989; Warner and Warner 1993; WHO 1986;1988.

Prevention is Basic to Health Reform

Model Legislative Language

A report of the Health Reform Advisory Committee Partnership for Prevention

This report is adapted from a paper, "Model Language for Prevention in Health Care Reform," prepared for *Partnership for Prevention* by Helen Halpin Schauffler, Ph.D., M.S.P.H., Assistant Professor of Health Policy and King Sweesy and Robert Wormack Chair in Medical Research and Public Health, University of California at Berkeley, under contract to The California Wellness Foundation.

Acknowledgement:

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INTRODUCTION

Preventive services and programs offer Americans the possibility of longer, healthier and more productive lives. To fully realize these benefits, preventive programs, policies and services should be integrated into health reform bills under consideration by Congress and state legislative bodies. At the request of the U.S. House of Representatives Energy and Commerce Committee, Subcommittee on Health and the Environment, this model legislative language has been developed to make explicit a goal that is implied in many of the proposed health reform bills: to maintain and improve the health status of the American people.

Until now, the debate about health reform has focused primarily on increasing access to health care and controlling rising costs. The following model legislative language is designed to bring to center stage two additional priorities that are central to successful health system reform.

- First, adopt "improving the health of the American people" as a primary goal of any health legislation.
- Second, view prevention broadly to include:
  - (1) personal/clinical preventive services;
  - (2) community-based prevention interventions; and
  - (3) social and economic policies for prevention.

How will we know whether sufficient prevention of the right types is incorporated into the disparate health system reform proposals? One way to answer this question is to measure the bill against a prevention standard. If a bill includes each of the following key components, it will have met the prevention standard:

- individual/clinical preventive services in the core benefit set determined by an ongoing scientifically objective process;
- community prevention activities of proven effectiveness;

- social and economic policy changes that make unique contributions to health improvement;
- a revitalized public health presence;
- data collection, analysis and reporting that show which system components and tactics work and which do not;
- research on how to create even more efficient and effective prevention services, programs and policies;
- increased numbers of primary-care providers with training in prevention; and
- public awareness interventions which contribute to an improved understanding of how prevention can promote good health and longevity.

If a bill does not meet this standard, it should be amended using the following model legislative language. This model language has been organized to include specific bulleted language recommendations, preceded by introductory comments and background.

Prevention works. We believe that this report is unique in its specific, comprehensive approach to prevention and identification of the greatest opportunities to improve the health of the American people, overall and for specific vulnerable populations.

MODEL LEGISLATIVE LANGUAGE

1. PURPOSE

PREAMBLE: The PREAMBLE to all health-care reform bills should explicitly state that the intent of the legislation is to improve the public's health.

- To ensure individual, family and community health and health security through health-care coverage for all Americans in a manner that improves the health of the American people, and ensures access to core public health and prevention services.

Health-care reform bills could also reflect this expanded purpose in their titles by incorporating the words "health improvement."

FINDINGS: In the section on FINDINGS, the current status of the health-care system necessitating health-care reform should be addressed.

- Rates of preventable illness, disability and premature mortality are high and significant disparities exist in the health status of population subgroups, including persons with low incomes, the elderly, children and specific minority groups.
- The public health systems operating at the state and local levels--services, data, priorities--are not integrated or coordinated with the medical care system.
- The systems of care for preventing and treating mental health and substance abuse are not well-linked with the medical care system.
- Any reform of the system requires a broad approach to prevention that incorporates clinical preventive services, public health and community-based health promotion services, and social and economic policy to promote health.
- Most health insurance plans do not cover a comprehensive package of benefits that meet the full range of health needs, including primary, preventive, and specialized services--including mental health and substance abuse.

PURPOSES: A section on PURPOSES should describe broad-based health improvement goals of the legislation.

- To improve the health status of the population and attain the health objectives for the nation as set forth in *Healthy People 2000*
- To promote healthy behaviors of individuals and families and the creation and maintenance of healthy environments in organizations and communities
- To guarantee the availability of the core public health functions in all states and communities

2. FEDERAL AUTHORITY

Most health-care reform bills give authority to a national health commission, council or board to oversee the reform of the health-care system at the Federal level. This Federal authority should have the expertise and be charged with the responsibility to protect and enhance the public's health.

MEMBERSHIP: The following expertise should be represented in the membership of the Federal authority.

- Expertise in population-based health information systems, public health, and health promotion and disease prevention

ANNUAL REPORT: The Federal authority should be responsible for monitoring and reporting to the American public on the health of the nation.

- The Federal authority shall prepare and send to the President and Congress an annual report addressing the implementation of health-care reform that shall include:

  1) recommendations or changes in the administration, regulation and laws related to public health and the coordination of public health and medical services; and

  2) data related to health improvements in the population.

PROCESS FOR UPDATING PREVENTION PROVISIONS: Health-care reform bills need to specify a process to be used by the Federal authority for periodically updating the prevention provisions. The model language requires the delegation of this responsibility to three expert panels, each of which addresses one of the essential elements of prevention—clinical preventive services, community-based prevention, and social and economic policy for prevention. The proposed processes and expert panels are based on the successful model of the U.S. Preventive Services Task Force.

- With respect to CLINICAL PREVENTIVE SERVICES the Federal authority:

  1) shall delegate responsibility to an Expert Panel on Clinical Preventive Services for periodic, rigorous review of the most recent scientific evidence on the clinical effectiveness and cost-effectiveness of clinical preventive services for individuals and groups of varying health status and health risk;

  2) shall require the Expert Panel on Clinical Preventive Services to report to them biennially with recommended revisions for the coverage and periodicity of clinical preventive services as specified in the standard benefits package, and provided under Medicare and Medicaid; and

  3) shall biennially update the specific items and services covered as clinical preventive services and the periodicity schedules as specified in the standard benefit package, and propose amendments to the Social Security Act to update the clinical preventive services provided under Medicare and Medicaid, based on the recommendations of the Expert Panel on Clinical Preventive Services.

- With respect to COMMUNITY-BASED PREVENTION the Federal authority:

  (1) shall delegate responsibility to an Expert Panel on Community-Based Prevention for the continuous and rigorous review of the most recent scientific evidence on the most effective and cost-effective community-based approaches to health promotion and disease prevention for healthy individuals, families and communities; and

  (2) shall require the Expert Panel on Community-Based Prevention to report biennially to them with recommendations on the most effective community-based approaches. The recommendations made within each of the priority areas identified in *Healthy People 2000* shall be listed in rank order based on their potential contribution to improving the population's health status.

- With respect to SOCIAL AND ECONOMIC POLICY for prevention the Federal authority:

  (1) shall delegate responsibility to an Expert Panel on Social and Economic Policy for Prevention for the continuous and rigorous review of the most recent evidence on the effectiveness of specific social and economic policies on health improvement; and

  2) shall require the Expert Panel on Social and Economic Policy for Prevention to report biennially to them with recommendations on the most effective social and

economic prevention policies and recommend changes in public laws, regulations and other public policies to improve the public's health.

- The Federal authority shall require the three Expert Panels on prevention to prepare an integrated report biennially to ensure that the priorities identified in each of the three essential areas of prevention—clinical preventive services, community-based prevention, and social and economic policy for prevention—are coordinated and build on each other in such a way as to ensure the greatest improvements in the public's health.

3. PREVENTION BENEFITS

CORE BENEFITS FOR CLINICAL PREVENTIVE SERVICES:

Coverage of clinical preventive services, whether defined in legislation or following enactment through regulation or by an outside authority, should be included in any health reform bill.

- Full coverage for a core set of age- and risk-appropriate clinical preventive services in the standard benefit package, including:
  - (1) immunizations;
  - (2) screening tests;
  - (3) periodic clinician visits; and
  - (4) preventive counseling and health education services.

PREVENTIVE COUNSELING AND HEALTH EDUCATION SERVICES:

When preventive services are specified in legislation, frequently the age- and risk-appropriate counseling and health education services are not specified in the same detail as immunizations or screening tests, or they are left out entirely. For those bills that designate a specific package of preventive services to be covered, the following counseling and health education services, as defined by the U.S. Preventive Services Task Force, should be included, in addition to the immunization and screening tests.

- Covers age- and risk-appropriate preventive counseling and health education services provided by health-care professionals or community-based providers to individuals for risk factors identified in the risk assessment provided as part of the periodic clinician visit (described below). These services include activities such as preventive counseling and health education for diet and nutrition, exercise, injury prevention, tobacco use, alcohol and drug use, sexual practices and dental health.

CLINICIAN VISIT:

A periodic health exam provided during a visit to a health-care professional should be covered at age- and risk-appropriate intervals.

- Clinician visit includes the following health professional services:
  - (1) a complete medical history
  - (2) an appropriate physical examination
  - (3) risk assessment
  - (4) targeted health advice and preventive counseling
  - (5) the administration of age- and risk-appropriate immunizations and screening tests

COST SHARING.

Preventive services covered in the standard benefit package shall be exempt from all co-payments and cost-sharing, provided that their use is consistent with any applicable periodicity schedule.

PROVISION OF HEALTH EDUCATION PROGRAMS.

Health-care reform should require health plans to make available and refer patients appropriately to health education programs provided by the plan or in the community to modify health risks.

- Health plans shall assess the availability of health education programs available in the community that have demonstrated their effectiveness in changing health behaviors. Health plans shall offer these health education programs to plan members based on an assessment of individual risks and learning styles. Health plans shall refer plan members to the health education program(s) that best meet(s) their needs. Coverage of health education programs may be subject to cost-sharing.

- Health education programs may include health education classes and training classes, self-care modules, community-based programs and computerized and telecommunications venues.

MEDICARE COVERAGE FOR PREVENTIVE SERVICES:

Some health-care reform bills incorporate Medicare into a single national health insurance program and others leave it as a separate program. If Medicare continues to be a separate program, Title XVIII of the Social Security Act should be amended to cover all of the clinical preventive services recommended by the U.S. Preventive Services Task Force for persons 65 years and older, as well as well-child visits and comprehensive clinical preventive services for children covered by the Medicare program. In addition, health-care reform must ensure that the Medicare program maintains coverage of all current benefits, including the covered clinical preventive services benefits for pneumococcal, influenza and hepatitis B vaccines, mammography, and pap smears. The following should be added as covered benefits under the Medicare program.

- That Section 1861(s) of the Social Security Act is amended by adding at the end thereof the following:

  (1) immunizations as recommended by the Advisory Committee on Immunization Practices (ACIP);

  (2) tests—The following tests are specified in this subsection.

  (A) total non-fasting blood cholesterol

  (B) blood pressure

  (C) visual acuity

  (D) physical breast exam

  (E) hearing exam

  (F) urinalysis

  (G) thyroid function for females

  (H) testicular exam for at-risk males

  (3) clinician visits—The clinician visits specified in this subsection are one clinician visit every year

  (4) preventive counseling and health education—The preventive counseling and health education services in this subsection are age- and risk-appropriate counseling services provided by health-care professionals or community-based providers (as defined previously) to the individuals for the risk factors identified in the comprehensive risk assessment provided as part of the clinician visit (described previously), including diet and nutrition, exercise, injury prevention, dental health, tobacco use, sexual practices, and alcohol and drug use.

  (5) well-child clinician visits, and clinical preventive services defined above as core benefits for children under 18 years.

MEDICAID COVERAGE FOR CLINICAL PREVENTIVE SERVICES:

Some bills incorporate Medicaid into a single national health insurance program and others leave it as a separate program. If Medicaid continues to be a separate program, Title XIX of the Social Security Act needs to be amended to require that all Medicaid recipients be fully covered for all of the clinical preventive services appropriate to their age, sex and risk status, as recommended by the U.S. Preventive Services Task Force.

- The Medicaid population shall receive the same age- and risk-appropriate preventive services benefits as those included in any Federally-defined standard benefit package

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES:

In many health-care reform bills, mental health and substance abuse services are treated differently than services for physical illness. Health reform legislation should strengthen the linkages between substance abuse and mental health services *and* the those of the medical system. Additionally, legislation should provide for comprehensive treatment based on appropriate assessment and referral.

- Mental health and substance abuse services shall be covered and provided based on an assessment of the individual's needs and, as appropriate, referral to an appropriate service provider.

4. COMMUNITY-BASED PREVENTION

SUPPORT FOR CORE PUBLIC HEALTH FUNCTIONS:

Authorize a new program to provide stable and adequate funding to support a fully effective public health system. Core public health functions must not be authorized and funded through Federal grant programs requiring discretionary appropriations. The core public health functions must be financed through the same vehicle that finances the personal health services provided in the standard benefit package. The capacity of state and local public health agencies must be strengthened to carry out the core public health functions and to increase the capacity of community-based providers to meet the special needs and concerns of the most needy and vulnerable population groups.

- The Secretary shall provide stable and adequate funds to States for the purpose of carrying out core public health functions, including:

  (1) data collection, analysis and assessment of public health data, vital statistics and personal health data, the acquisition and installation of hardware and software, personnel training and technical assistance to operate and support automated and integrated information systems;

  (2) activities to protect the environment and to assure the safety of housing, workplaces, food, and water;

  (3) investigation and control of adverse health conditions and threats to the health status of individuals;

  (4) public information and education programs to reduce risks to health;

  (5) accountability and quality assurance activities;

  (6) provision of public health laboratory services;

  (7) training and continuing education for the public health professions;

  (8) leadership, policy development, coalition-building, and administration activities;

  (9) integration and coordination of the prevention programs and services of health plans, community-based providers, local and state health departments, and other sectors of state and local government that affect health, including education, labor, transportation, welfare, criminal justice, environment, agriculture, and housing; and

  (10) research on effective and cost-effective public health practices.

PUBLIC HEALTH REPORTING.

The bill should require States to submit annual reports to the Secretary on the health status of the population and measurable objectives for improving the public's health.

The Secretary shall require the States to submit an annual report addressing the following:

- comparison of measures of the State's public health system (at the State and local levels) compared to relevant objectives set forth in *Healthy People 2000*;
- a description of health status measures to be improved within the State (at the State and local levels) through expanded public health functions and health promotion and disease prevention programs;
- measurable outcomes and process objectives for improving health status;
- information regarding how Federal funding has improved population-based prevention activities and programs;
- a description of the core functions to be carried out at the local level; and
- a description of the relationships between the State's public health system, community-based health promotion and disease prevention providers, and health plans.

5. HEALTH RESEARCH

HEALTH RESEARCH INITIATIVES:

The bill should provide new grant funds to support health research initiatives that identify the most effective and cost-effective strategies to improve the public's health.

- The Secretary shall insure that the Public Health Service conducts and supports health research

- In carrying out this initiative the Secretary shall give priority to conducting and supporting research:

  (1) that reflects the full range of approaches identified in the priority areas of *Healthy People 2000*, including research to identify the most effective approaches to delivering clinical preventive services, community-based health promotion and disease prevention, and social and economic prevention policy;

  (2) on the appropriateness and effectiveness of alternative community-based and clinical strategies for preventive care; integrating preventive services into primary care; effectiveness of preventive counseling and health education; efficacy and cost-effectiveness of clinical preventive services; the effectiveness of employer incentives to offer and strengthen worksite health promotion programs; the effectiveness of community health workers on the quality and outcomes of care;

  (3) on the impact of health-care reform on health delivery systems; community-based injury and illness prevention; methods for risk assessment and risk adjustment; factors influencing access to primary care, preventive services, community-based health promotion and public health; individual health decision-making; and the feasibility of developing incentives for worksite health promotion programs; and

  (4) the development of clinical and public health practice guidelines, the dissemination of such guidelines and the assessment of the effectiveness of such guidelines.

6. HEALTH DATA SYSTEMS

NATIONAL PERFORMANCE MEASURES:

The health-care reform bills should require the development of standard measures of system performance and evaluation and reporting of performance that address health status and prevention. The availability of uniform health data is critical to assessing the performance of the health-care system. Prior to the development of national measures of performance and operation of a national health information system, the Secretary shall assess current measures and data systems to establish a baseline report of the performance of the system.

- The Federal authority shall authorize the development of a set of national measures of performance of the health-care system to be used to assess the health and risk status of the population, the provision of health-care services, and access to such services.

- The measures shall incorporate standards identified by the Secretary of Health and Human Services for meeting public health objectives as defined in *Healthy People 2000*.

- Not later than one year after the date of enactment of this Act, the Federal authority shall establish and oversee a performance-based program of quality management and improvement designed to improve the health and risk status of the population, enhance the quality, appropriateness, and effectiveness of health-care services, and access to services.

- National measures of quality performance shall be selected in a manner that provides information on the following:

  (1) health promotion, including population-based health status measures, prevalence of behavioral and environmental risk factors, incidence of preventable morbidity, injury, and mortality;

  (2) prevention of disease, disorders and other health conditions;

  (3) individual level health risk and health status, including behavioral health, functional, and mental status;

  (4) access to health-care services by consumers,

  (5) appropriateness of health-care services provided to consumers,

  (6) outcomes of health-care services and procedures, and

  (7) consumer satisfaction with care.

- The Federal authority shall evaluate the impact of this Act on the health and risk status of the population, the quality of health-care services in the United States and access of consumers to such services.

HEALTH INFORMATION SYSTEM:

Any health-care reform bill should develop standard measures for evaluating individual and public health.

- Not later than two years after the date of enactment of this Act, the Federal authority shall develop and implement a health information system for the collection, reporting and regulation of health information.

- The health information shall be collected and reported in a manner that facilitates its use for the following purposes:

  (1) improving the ability of health plans, health-care providers and consumers to improve the health of the population;

  (2) monitoring changes in the health status of the population;

  (3) supporting public health functions and objectives;

  (4) health-care planning, policy development, policy evaluation and research by the Federal, state and local governments;

  (5) improving the ability of health plans, health-care providers, and consumers to coordinate, improve and make informed choices about health-care;

  (6) assessing and improving the quality of care; and

  (7) measuring and optimizing access to care.

ENROLLEE DATA:

The bill should include provisions for the collection of health and risk status data on all persons enrolled in the national health-care system by requiring completion of a consumer survey as a requirement for enrolling in a health plan. These data will be used both for personal health information systems for all eligible individuals, as well as for the collection of comprehensive population-based data on health risks and health status.

- Eligible individuals shall be entitled to benefits under this Act, upon completion of a comprehensive health risk and health status consumer survey upon enrollment, and periodically thereafter.

HEALTH INFORMATION SYSTEM PRIVACY STANDARDS:

The Federal authority should promulgate standards respecting the privacy of individually identifiable health information that is in the health information system. Such standards should include safeguards for the security of such information. The standards established should apply to all data collected by Federal and/or private health information systems.

CONSUMER INFORMATION AND MARKETING.

Consumers need to be provided clear, factual information that allows them to make informed health choices. This information should incorporate a broad perspective on preventive services and programs, designed to both educate and encourage their utilization.

- A summary of the annual national quality performance report, including population-based health and risk status, health outcomes, preventive services utilization, and patient satisfaction, shall be made available to all consumers.

- Information on the annual performance of individual health plans in a state and local area, addressing the quality measures of population-based health and risk status, health outcomes, preventive services utilization, and patient satisfaction shall be made available to all consumers.

- Information shall be made available to all consumers on the extent, availability and individual and societal impact of preventive services and programs. Information shall be designed and targeted to promote healthy behaviors and lifestyles in both general and specific at-risk populations.

TECHNICAL ASSISTANCE:

Public health agencies at all levels are poorly equipped and staffed in health information technology. Therefore, additional provisions need to be included in health reform legislation to provide information and technical assistance to the states, health plans and health-care providers to enable their full participation in and use of health information systems. Specific attention needs to be given to the linkage of community-based information systems with patient care information systems.

- The Federal authority shall provide information and technical assistance to the States, health plans and health-care providers with respect to the establishment and operation of automated health information systems. Such assistance shall focus on:

  (1) the development and strengthening of community-based health information systems;

  (2) the linkage of community-based information systems with patient care information systems.

7. PROFESSIONAL TRAINING

FUNDING PROGRAMS: Health-care reform bills should authorize funding to support projects to train additional numbers of primary care providers and to retrain providers in primary care, public health, and community-based health promotion and disease prevention.

- The programs described in this section include programs to train additional numbers of health-care professionals in primary care, including programs to enhance training in clinical preventive services and health education, and training in community-based health promotion and disease prevention, addressing the relationships between the social, economic, and physical environments and the health of the population. These programs shall be available in the training programs of primary care physicians, physician assistants, nurse practitioners, and certified nurse-midwives.

- The programs described in this section include programs to retrain mid-career primary health-care and public health professionals in community-based health promotion and disease prevention, including public health education, epidemiology, biostatistics, nutrition, coalition- building, community development and participation, public policy, mediation and advocacy.

Senator DODD. The subcommittee stands adjourned.
[Whereupon, at 12:05 p.m., the subcommittee was adjourned.]

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