Emily Anne Staples Tuttle papers.

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LIB AND LEARN: Smith Day Quiz, 1972

PART I. Each of the following answers contains the syllable "lib".
Examples: A liberated woman's sense of balance: equilibrium

Methodical (and liberated): deliberate

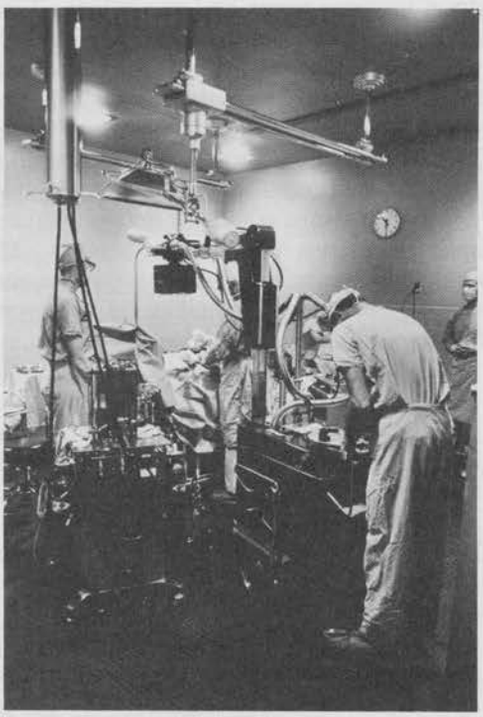
1. Hangout for liberated, studious women _____
2. Articulate (and liberated) _____
3. Chaste (though liberated) _____
4. True sign (astrol.) of a liberated woman _____
5. Text for a liberated prima donna _____
6. Monster in the tempest _____
7. Liberated woman's excuse _____
8,9. Two favorite pianists of liberated women _____ and _____
10. Arab who said, "Open, Sesame." _____
11. What a tense liberated woman needs to be tranquil _____
12. Liberated woman's drink _____
13. Liberated woman's drink in Havana _____
14,15. Two liberated African countries _____ and _____
16. Liberating gift weapon from a lady of the lake _____
17. Pacific headquarters for surfing, liberated women _____
18. To label libbers with lies _____
19. Every liberated housewife knows "If it's fresher than _____, it hasn't been picked."
20. A liberated princess in the 1930s _____
21. Describes a liberated woman who's never wrong _____
22. Describes a big gun on an elephant hunt (or a good lib leader) _____
23. Without a script (while speechmaking) _____
24. A flighty, liberated woman _____
25. Describes a libber who'll believe anybody _____
26. Liberated woman's primal instinct (Freud) _____
27. Marathon talk in Washington _____
28. Liberated sea creature _____

PART II

Match the descriptive phrase or quote in column two with the right name in column one

Lucy Stone ___
Kate Millett ___
Alexander Pope ___
Simone de Beauvoir ___
Martin Luther ___
Carrie Chapman Catt ___
Bella Abzug ___
Jane Addams ___
Germaine Greer ___
Valerie Solanis ___
Betty Friedan ___
Margaret Sanger ___
Rudyard Kipling ___
Gloria Steinem ___
Victoria Woodhull ___
Mary Wollstonecraft ___
Louisa Mae Alcott ___
Norman Mailer ___
Harriett Tubman ___

a. Won Nobel prize, worked in Chicago slums
b. SCUM leader, shot Andy Warhol
c. Founder of birth control movement
d. "A woman is only a woman, but a good cigar is a smoke."
e. Author of "The Second Sex."
f. Set precedent by refusing to take husband's name.
g. "God created Adam lord of all living creatures, but Eve spoiled it all."
h. Author of "Sexual Politics."
i. Turkish beauty who balked at haren life.
j. Ran for the presidency.
k. "Most women have no characters at all."
l. Author, "The Female Eunuch."
m. Led suffrage movement to fruition.
n. Smith alumna, wrote "The Feminine Mystique."
o. First woman elected to Congress as strong feminist
p. Smith alumna, editor of Ms.
q. "I would rather be a spinster and paddle my own canoe."
r. Wrote first great feminist document, "The Vindication of the Rights of Women," 1792.
s. President's wife who spoke up for women's rights.
t. "The prime responsibility of a woman probably is to be on earth long enough to find the best mate possible for herself and conceive children who will improve the species."
u. Courageous freer of slaves



Health Insurance: The Canadian Experience

by Dr. K. C. Charron

The Canadian experience with health care may be particularly relevant to the U.S. future in health. Both nations have a federal-state type of government and the two health systems—if they can be called systems—are very similar. They have a common approach to the education of health professionals and technologists; hospital and health patterns follow a similar course; fee-for-service is prominent in both countries; each country has been searching for new and innovative arrangements to improve health care; and medical research is supported similarly—though not as adequately in Canada as in the United States.

The great difference is that Canada relies to a considerable extent on universal, publicly funded health insurance to finance its national health services. Canada has had a number of years of experience in operating a universal health insurance program, and the debate that preceded its enactment was highly similar to the debate going on now in the United States. Canadian mistakes may provide as valuable a lesson as Canadian successes.

Many features in North American health services are as good as anything in the world and we should build on these and encourage cooperation. One or a number of rotten apples should not be used by inference to imply that there are many more in the barrel. Certainly health services has its quota of rotten apples and they should be identified and removed. However, a very substantial proportion of our health professionals and technologists provide a high quality of care and are well motivated, so we should not go overboard in stressing the negative and the sensational.

The scope of the Canadian national health program consisted, in the beginning, of two major components. Hospital insurance and diagnostic services were introduced together in 1958. Then in 1966, the Medical Care Act, primarily providing insurance for physician services, became effective. Both of these arrangements are now melded together and represent the basis for federally supported health insurance in our country. In addition, several of the provinces, on a selective basis, have extended these arrangements to cover nursing homes, home care, dental programs for children and some out-of-hospital prescription drug benefits. More than 80 percent of the total cost of health care in Canada is supported by public financing.

In programs of this magnitude and complexity, a basic philosophy is essential—and much of the basic philosophy of health care is held in common in the United States and Canada. It is this basic philosophy which is being debated with such vigor in the United States and some of the features in the Canadian pattern may be particularly relevant and might be adapted to the United States:

- Health care in Canada is available to all residents

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upon uniform terms and conditions. This means that all residents are eligible for coverage regardless of pre-existing conditions, age, or any other factor which might make that person a poor risk. It also means that everyone is treated in the same way—insured for benefits without economic status being identified. Poor people who could not afford premiums—or for a variety of reasons could not obtain insurance—became insured persons eligible for benefits. Thus the Canadian program requires universal coverage for the whole population and makes the program responsible for the availability of services.

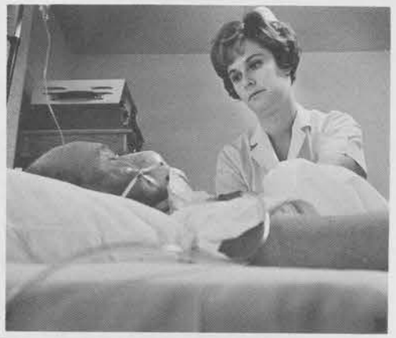
- Eligibility for benefits is based on medical necessity, with no time or monetary limitations. Costs associated with catastrophic situations are part of the insured arrangement. Medical necessity is an important cornerstone of our program, so it is a practical and reasonable feature to have no time or monetary limitation. Medical necessity is also important in determining when benefits should be provided and in controlling excessive utilization.
- The plan is publicly administered and open to public audit. In each province a public agency or agencies assumes the responsibility for administering the health insurance programs and this administering body is subject to public audit.

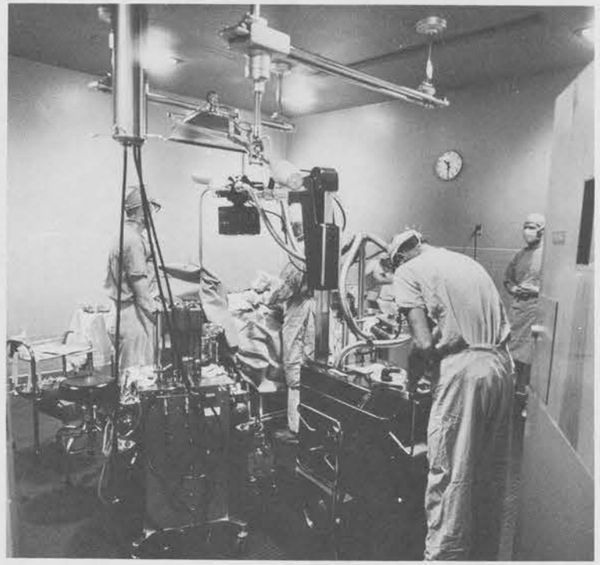
The Canadian federal government required universal coverage from the beginning of a program and, in order to achieve it, two provinces used private insurance agencies at the start to assist with administration of medical care, but not for hospital insurance. For example, in Ontario a consortium of private insuring agencies formed part of the administrative pattern at the start of the Medical Care Program. They provided this service on a non-profit basis and met the requirement of public audit. This arrangement lasted for two years and then, by mutual agreement, the consortium ceased to participate.

- In a phased or staged program, benefits in the covered segment should be comprehensive and conform to the basic philosophy.

The Canadian hospital insurance and diagnostic services program conforms to the basic philosophy and pays for all services rendered in a hospital at standard ward level—with the exception of those provided by the attending physician or consultants who may be called in on a particular case. The inpatient benefits may be extended to out-patients and most provinces have extensive out-patient benefits. Similarly, the Medical Care Act provides that all necessary services rendered by medical practitioners are insured. In other words, hospital insurance provided comprehensive coverage for hospital care and the Medical Care Act did the same thing for physician services. Both programs conformed to the basic philosophy established for health insurance.

- A publicly administered, universally available health insurance program as in Canada is much more than a means of paying individual benefits. It is an important technique for financing health services. This



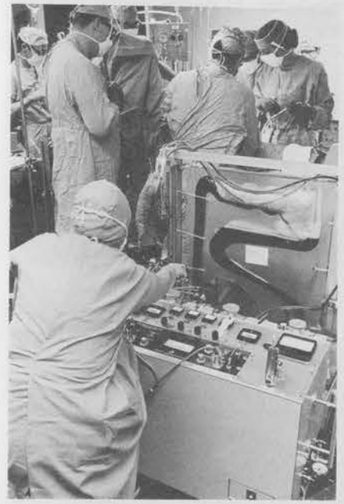


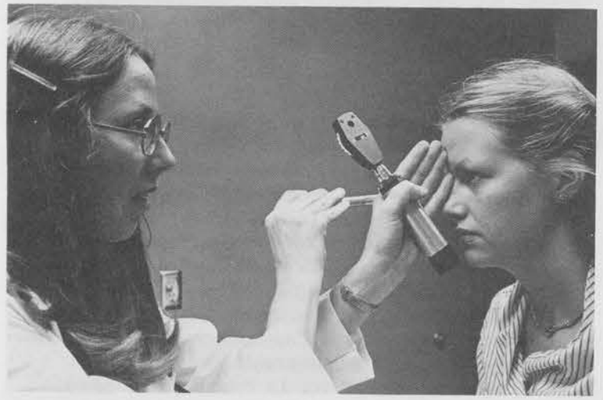
responsibility for health services means that much more attention has to be paid to health resources development and organization.

- Portability of benefits within a country and out of country benefits are also considered essential. In this regard, Canada hopes that when the U.S. program begins, reciprocal arrangements will be made to ensure continuity of benefits for people taking up residence in the other country.
- Freedom of choice is guaranteed for insured persons and for the providers of service on whether they want to participate in the national program.

Those are the general features associated with the basic philosophy of the Canadian program. Among the many points discussed in the U.S. proposals, the four features that seem to be the most important are phasing; medical organization; resource development; and preventive health care.

Phasing or staging may be defined as "a stage in a sequence of events." As mentioned, universal, nation-





wide hospital insurance and diagnostic services were introduced in Canada in 1958 and physician services insurance in 1966, but preceding both of these was a substantial health grants program, beginning in 1948. Canada started with hospital insurance for good and compelling reasons in 1958 and did not follow up with physician services insurance for eight years. Hospital care became overemphasized and was the most expensive component. If carefully chosen, the U.S. sequence of events can avoid this. We might have avoided part of the consequence if there had not been a span of eight years between the two major events. Therefore, timing is also important.

If certain conditions are met, phasing or staging can be a good approach for two primary reasons. First, while national health insurance is largely a transfer of funds from the private to the public sector and very little new money is involved, a comprehensive national health insurance program calls for a very large public budget and it is much easier to build up to these amounts in phases. Also, national health insurance is a vast and very complex arrangement and even with the best planning, many major problems will occur. Staging makes it possible to start with a manageable package, gain experience and get ready for subsequent events.

These are the two primary advantages in a phased or staged approach. But, phasing or staging may be considered a good approach only if certain conditions are met. Among them are:

—The overall objective—comprehensive national health insurance—must be clearly and publicly stated and preferably enshrined in legislation.

—The same basic principles and philosophy of the comprehensive program must be applied to the initial and subsequent steps. The same is true of the preferred methods of financing, that is, applied to the initial and subsequent stages.

—The timing sequence must be sufficiently short so imbalances or distortions are minimized and cannot become fixed.

—The amount of money required for health resources development must not diminish during a phased arrangement and must be at least as large as that required for an unphased approach.

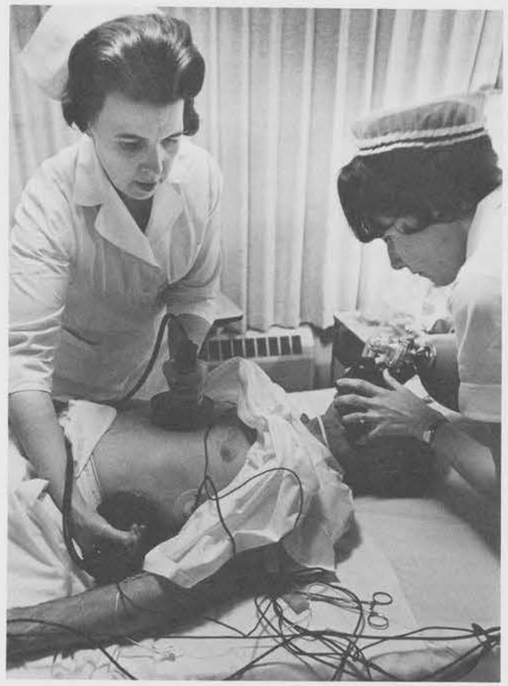
—Effective cost control measures must be introduced at the start of the program. If this condition is not met, the delay caused by phasing may be very expensive.

Organization can be expressed in a series of maxims which might be stated as: evolution is better than revolution; cooperation is better than confrontation; participation of interested parties is important; building on what you have is better than trying to wipe the slate clean and start with nothing; and the four Es of efficiency, effectiveness, economy and evaluation are important.

North American technology and resources are excellent but in the organization of health services, we are still in the horse and buggy days. The financing of health services from public funds makes the development of a coherent management and administrative structure imperative. Major changes cannot be effected overnight and one must be sure that change offers advantages, not just "change for the sake of change." Consumer participation is essential but so is the participation of the providers. There are many features in our health services about which we can be justly proud and they form a good base for development.

The days of "add on" are over and most new programs will have to be accommodated within the means at our disposal. For instance, the reorganized structure which appears to be developing in Canada is a regional, decentralized system with participation as a strong component.

In a decentralized organization, responsibility must be paralleled by authority—if you are responsible you must have the authority to do something about it. It also means that you inherit the pleasant tasks and also the difficult and unpopular decisions and you must be prepared to make these decisions. If people under-



stand why the decision is made and are involved, the decision makers should gain respect if not popularity.

A major challenge will be to develop education and training programs for senior and mid-management personnel, for health planners and other key people in the health services organization. Similarly, health care research will become more prominent. These are just two examples which stress the importance of including education and research, along with health services, in the comprehensive package.

Resources development has to be integrated with proposals for national health insurance.

Canada has a health grants program similar, in some ways, to the one in the United States. This does not minimize the importance of resources development funds tied to the comprehensive objective. Under such an arrangement, the emphasis is likely to move from an ad hoc project approach to a program-centered effort. While phasing or staging decreases the amount of money required to operate the more circumscribed elements, this doesn't diminish the need for health resources support. It may in fact be enhanced as pilot projects may fill some of the gaps not covered by the current stage in development of the insurance arrangements.

Promotion and prevention in the health field always includes the hazard that national health insurance may be developed with a focus on illness to the exclusion of health. This occurred in Canada and we have a long way to go to correct this imbalance. However, there are encouraging signs, among them a publication titled: "The Health Field."

It said, "Good health is the bedrock on which social progress is built. A nation of healthy people can do those things that make life worthwhile and as the level of health increases so does the importance for happiness. . . .

"The health care system, however, is only one of many ways of maintaining and improving health," the pamphlet says. "Of equal or greater importance in increasing the number of illness—free days in the lives of Canadians have been the raising of the general standard of living, important sanitary measures for protecting public health and advances in medical science.

". . . The government of Canada now intends to give to human biology, the environment and lifestyle, as much attention as it has to the financing of the health care organization so that all four avenues to improve health are pursued with equal vigor. Its goal will continue to be not only to add years to our life but life to our years so that all can enjoy the opportunities offered by increased economic and social justice," it concludes.

This working document, presented by the minister of National Health and Welfare, has a concept which deserves substantial emphasis. Health promotion and prevention should become prominent in our health system in the future.

A mistaken U.S. notion makes Canada a "whipping boy" or "bad example" in U.S. discussions of health programs. It is not justified and the record should be set straight, hopefully without a mass of statistics.

The three features in the Canadian program frequently used as reasons for not establishing a national health insurance program are: 1) overall costs and cost escalation; 2) excessive utilization; and 3) high costs of administration. I submit that the Canadian experience in each of these features provides compelling reasons for adopting, not rejecting, national health insurance.

A great worry in both our countries has been that overall costs of providing health care have been outpacing our sources of revenue and that we are rapidly pricing ourselves out of business.

This was the situation in Canada, but Canada now appears to have established an equilibrium and balance between escalating costs and sources of revenue. From 1970 to 1974 our total health expenditures stabilized in relation to Canadian gross national product (GNP). From 1965 to 1974, Canadian health expenditures as a percentage of GNP increased by about 1 percent whereas the U.S. percentage increased by 2.1 percent. The Canadian percentage of GNP has been stable at about 7 percent for some time, while the American percentage was 8.6 percent in fiscal 1976 and is about 9 percent now. This is not to deny that circumstances, such as major developments in technology, may justify an increase in health care expenditures, but in Canada, that decision is in our hands in an organized program.

In 1974, the per capita cost of our total health expenditures was $430; the U.S. cost was $528. Rather than discourage, these few figures should be good reasons, in themselves, for national health insurance.

In considering cost controls the supply of resources dominates the picture. The Canadian experience has demonstrated three important features.

—First, with regard to institutional beds, if you build them you fill them. However, the bed is only the outward sign of a complex system. In rationalizing beds, you must also rationalize the different illness patterns and the service required by the patients who, from time to time, occupy these beds. Patient mobility in the system is also important.

—Second, in a fee-for-service, private enterpreneurial system, the influence of the marketplace does not apply and there is a direct relationship between the number of physicians and the cost of physician services. Fee-for-service does have advantages in certain parts of the Canadian system and methods of payment should suit the circumstance, so I'm not arguing against fee-for-service totally.

—Third, demand for health services is insatiable. All of these require attention in resource development and its relationship both to reasonable availability and reasonable cost constraint. In Canada we can't afford the luxury model, but we also believe the trimmings are not important to quality of care and availability. They add to costs but not to benefits.

Utilization, the second bogey, is frequently raised in such statements as: "People will come in such numbers that services will be swamped and quality of care will deteriorate." It is also used as an argument to support co-insurance and deductibles.

Increased utilization in Canada is frequently pointed to as an example. It is quite correct to say that increased utilization of services, particularly in our hospitals, did occur and this was very accurately anticipated by our health economists. Much of this increase was a positive and good development. At the start of hospital insurance we were in a stage of development and there was a need to ensure better resources and better distribution. Because they were insured, people could avail themselves of these services and did not have to fear bankruptcy in the case of catastrophic situations.

Medical necessity was the control mechanism, but we did place an unfair burden on our physicians when we started our insured arrangements with hospital insurance. It made it very difficult for physicians to resist admission to hospital when they knew there was a financial advantage associated with hospital care. This did lead to an overemphasis of in-hospital services, a situation which the United States can avoid in its phasing arrangements. We believe that quality

of care has been enhanced by providing better resources with improved distribution. Current efforts to establish improved organizational patterns will brighten this picture.

The Canadian experience with co-insurance and deductibles is that when they are reasonable, they do not control utilization. And placing them at a level where they might deter some from receiving a service creates the intolerable circumstance of making a service accessible to those who can afford to pay and denying it to those who cannot. The only equitable solution is to use a yardstick such as medical necessity to determine when benefits should be provided.

Public administration, open to public audit, was decided upon in Canada. Three compelling reasons provoked this decision. One, you can't turn over the responsibility for administration to an outside agency not involved in the development of the system; two, the insured population is entitled to a maximum return in the form of benefits, whereas profits substantially reduce this return; and three, the basic philosophy is to finance a service and not just pay for individual benefits.

Current costs for administration in Canada, even in provinces involved in premium collection, average 2.1 percent for the 10 provinces. So even allowing for indirect costs, the return in form of service and benefits is at least 95 percent for this publicly administered program. In the United States, administrative costs for private insurance carriers consistently runs at about 14 percent.

In two provinces a multiple carrier system was tried at the start of physician services insurance. Commercial insurance agencies formed a consortium and agreed to administer the program, on a non-profit basis, for the people insured by private carriers prior to the start of the program. By their participation they made it possible for a province such as Ontario to achieve universality of coverage on day one and they deserve a great deal of credit for this. However, after two years, and I believe by mutual consent, it was agreed that they would withdraw. Their approach to payments was different and not compatible with the public program and it was not possible to develop important features such as physician and patient profiles.

So much for the misconceptions and myths about the Canadian system: it should encourage and not discourage you. The most important reason for national health insurance in any nation is that health care should be considered a right and not a privilege. Publicly funded health insurance is the way to translate that right into a reality.

As for Canada, no utopia exists: we have a long way to go, but we have also come a long way. National health insurance is a very good and worthwhile development and offers a practical solution to many of Canada's current and future problems in the health field. ■

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AFL-CIO American Federationist

WOMEN

and

HEALTH ★ SECURITY PROGRAM

HEALTH SECURITY

Women and Health Security

by OLGA MADAR,
President of The Coalition
of Labor Union Women.

Revised June 1977

WOMEN AND HEALTH SECURITY

According to insurance actuaries . . .

Women use more health services than men do.

They see physicians more often. They have more surgeries. They use more prescription drugs. And, they bear children.

But how much of what we women use is really needed? Women have long suspected that some services are unnecessary. Now there is proof. In 1975 doctors performed over 2,400,000 unnecessary operations, many of them hysterectomies—a major surgery requiring removal of the uterus. And this is only one example. As it turns out, women receive a lot of expensive health care that they don't need. The irony of the situation is this: the system that fosters this swindle turns around and charges us more, labelling us "bad risks." Well who makes us "bad risks" in the first place?—the system, as represented by private health insurance companies and health care providers. These people play a clever game: first they see that women use more health care at a greater expense (most of which *we* end up paying); then, on the basis of our increased usage, they classify us as "bad risks," and "clunkers."

The "bad risk" syndrome has a number of unfair consequences—

Women cannot obtain adequate health or disability coverage on an individual basis. Often, widows and divorcees with children are unable to obtain any health insurance for themselves or their children.

Married women find that the medical costs of bearing children may not be completely covered under their husbands' policies. Problems related to female reproductive organs are routinely and deliberately excluded from coverage. New born babies are sometimes not covered for the first 14 days of life.

Clearly, American women can no longer afford the "tender mercies" of insurance actuaries. We need a comprehensive non-discriminatory system of health care services that provides adequate delivery and cost controls.

THE HEALTH PROBLEMS

A recent study showed women make 5.6 visits to doctors for every 4.3 visits made by men. Are women less healthy, or is the system forcing unneeded care on us? Whatever the reason, insurance companies often make us pay 150% higher premiums than men.

Hysterectomy is now the number one operation in the U.S.—725,000 were performed last year at an average cost of over $2,500. To those running the system, this operation falls into the category of "preventive medicine." This year, half the women in the country over the age of forty will be advised to undergo hysterectomy. Much of the surgery actually performed will be unnecessary.

Cancer is the leading cause of death among women aged 30 to 53; at the present rate, one in every 15 American women will develop the disease at some time.

Breast cancer is the most common cancer in women. In 1974, 90,000 new cases were diagnosed and 33,000 women died of it—in spite of the fact that at least half the cases are curable if detected early. There has been no significant reduction in the mortality rate for this disease in the past 35 years.

Eleven thousand women die annually from cervical cancer. The rate could be dramatically reduced if every woman had a Pap test regularly. These check-ups permit diagnosis of cancers or pre-cancerous conditions at a time when they are most easily cured. Yet, according to a recent study, only 53 per cent of our women have had a Pap test.

Early diagnosis of diabetes, one of the nation's more common ailments, is an important factor in controlling the disease. Of the estimated four million diabetics in the United States, two out of three are women.

One million 600 thousand Americans are diabetic and don't know it. Yet simple blood glucose tests, readily available, can pinpoint or indicate a proneness to the disease. Overlooked or neglected, diabetes leads to serious health

problems. It is the second most common cause of blindness in the U.S.

Recent studies indicate that women are five to ten times more susceptible to gonorrhea infection than men. This, too, is easily cured if diagnosed early. If undetected, it can cause sterility or blindness in babies born to infected mothers.

THE HEALTH DELIVERY SYSTEM

The shortcomings of the American health care system are dramatically evident in an area of particular concern to women, the infant mortality rate. Our country ranks 15th among the countries of the world in deaths of infants during the first year. We lost 16.7 babies for every thousand born in 1974. Were our rate the same as Sweden's — 9.2 deaths per thousand — nearly 30,000 babies would have been saved.

A study done by the Columbia University School of Public Health contains estimates showing that more than 51 per cent of infant deaths in some New York hospitals could have been prevented by proper pre-natal care.

Despite the urgent need for pre-natal care, more than one-third of all women having babies in American public hospitals receive no such services.

THE COSTS AND INSURANCE CRISIS

As users of health services women should be concerned about the spectacular rise in the cost of medical care. During 1976, it cost an average of $638 for health care for every member of the family.[1] Experts predict these costs will double over the next five years.[2]

Health care is now about one-eighth of *ALL* personal consumption expenditures and still soaring. But only one-fourth of personal expenditures for health care is covered by private health insurance.

Increased costs of health insurance do not signal increased benefits. Blue Cross-Blue Shield members in many parts of the nation are exper-

1 Social Security Bulletin, April, 1977

2 Congressional Budget Office Report—March, 1976.

iencing 30%—40% or even 60% hikes in monthly premiums.

Catastrophic and chronic illness do not strike everyone. But even a typical hospital stay of 10 days costing about $2,000 now could wreck a family budget. Two-thirds of American families would go into debt if they had to pay $2,000 in medical bills. With hospital rooms in many areas at $200 per day (and still soaring) it is easy to run up such a bill. A New York woman recently paid doctor's and hospital bills of $2,050 for delivery of her baby. A Washington, D.C. woman received a nine-foot-long hospital bill totaling $9,300 for care of her premature baby for 1½ months. Private health insurance often pays only about 10% of maternity costs.

WORKING WOMEN

There are 43.7 million working women in the United States. They comprise 42% of the total work force. Women's salaries, on the average less than $8,000,[3] contribute to family income and are essential in maintaining the family standard of living.

Despite their importance to the economy, women are often unable to get adequate health and disability insurance. They invariably receive less coverage than is available to men—*and they pay more.*

Why this discrimination?—because commercial insurance companies are profit, not health oriented, and they are run by men. Their idea of "the perfect risk" is the healthy person who has little chance of using his insurance. Women, whose actuarial experience is higher—remember why?—are considered bad risks. They are "losers," and "clunkers," out to defraud and bankrupt the insurance industry. That's the rationale of the industry as expressed in Congressional testimony.

Employers are penalized for hiring women. The agent's manual of a large insurance company warns employers that hiring females may result in higher claims' costs and health premiums. If

[3] Current Population Survey, March, 1976. Census Bureau—$7,504.

benefits on females represent more than 11 per cent of the total, group health insurance benefits go way up. More than likely, the employer will avoid hiring women.

Aetna Life and Casualty, the nation's largest commercial health insurance company, admitted before the Senate Antitrust and Monopoly Subcommittee that when 60 per cent of an employer's work force are women, the insurer writes group health policies only if each employee takes out a life insurance policy. The life policy assures profits.

DISCRIMINATION

Another marketing practice is the system of "exclusions" or "riders." Insurance companies can refuse payment on treatment of any disease or disability if the condition existed *prior* to the signing of an insurance contract: old or pre-existing illnesses are often "excluded" from coverage. For example, a diabetic may be allowed to purchase coverage, but no payments will be made for any medical treatment or hospitalization resulting from or related to diabetes. Commercial health insurance is thus of limited value to those with chronic conditions.

Many companies place women in double jeopardy. Women are not only subject to the usual riders, but are also denied coverage for specific female disorders, such as those related to the reproductive organs. Most companies place sharp restrictions on maternity coverages. Benefits are optional, requiring higher premiums and a waiting period of ten months before reimbursement of the insured party.

The Pennsylvania Insurance Commissioner's Advisory Task Force Report on Women's Insurance Problems found maternity benefit discrimination in both non-profit and commercial plans. For example, Pennsylvania Blue Shield Plan B paid a flat rate of $90.00 for a normal delivery in 1974. That is 37 per cent of the average $243 doctor's charge (excluding hospital costs) in Philadelphia at that time. Yet, reimbursement for an appendectomy was $150—70 per cent of the bill.

Inadequacy of maternity services isn't the only

rip-off. Commercial insurance firms offer little or no coverage for family planning, contraception, fertility-related treatment and abortion—all are critically necessary to the delivery of healthy children or prevention of unwanted pregnancies.

When it comes to disability insurance, women find it almost impossible to get equal treatment with men.

A 30 year old, "superior risk" male can buy accident and sickness insurance from New York Life, paying benefits from the 31st day of disability to age 65. For this coverage in 1972, he paid $49.94 annually per $100 of monthly benefits. A woman of the same age and risk category paid $58.99 for benefits lasting only five years.

The Equitable Life Assurance Society offered plans providing monthly benefits of up to $1,500 to men classified as AAA (least hazardous occupation). Women in the same risk category and income bracket could receive a monthly maximum of only $700. Equitable refused to insure "A" rated women at all.

Yet recent studies prove that women are *more* reliable health-wise than men:

- A Public Health Service Study showed that men are more susceptible to chronic conditions such as heart trouble, arthritis, rheumatism and orthopedic impairment than are women, and thereby have a higher work absentee rate.
- A University of Chicago study showed that the duration of health-related absenteeism is shorter for women than for men.
- A Metropolitan Life Insurance Co. study showed that the incidence and length of hospitalization is greater for male than for female employees.

Insurers are suspicious of women who work for relatives. A woman who works for her husband probably cannot buy disability insurance. But if her husband works for her, he probably can purchase coverage.

A divorced woman is another insurance "clunker". Though she can obtain insurance, she may not enjoy the same benefits provided by her husband's policy—even if she has legal custody of their children.

UNNECESSARY SURGERY

Women are victimized by a health care system that prescribes extreme measures of treatment—usually surgery—rather than preventive care. In 1975, 725,000 hysterectomies were performed, a 25% increase from 1970.

Pre-surgical screenings carried out by leading medical schools in New York indicate that from one-fourth to one-third of the recommended hysterectomies for wives of union members could not be justified, and that another 10 percent were of questionable value. The same study shows that specialists could not support physicians' recommendations for up to 43% of the dilatation and curettage procedures and up to 21% of the breast operations. It is estimated that the prescreening process saved union health plans more than $500,000 in two years, and spared members untold anguish.

Unnecessary surgery is being performed even though the medical profession has the responsibility to monitor itself. But the monitoring isn't working very well. Dr. Thomas Chalmers, Dean of Mt. Sinai School of Medicine, told the American College of Physicians in 1974 that doctors kept prescribing silbesterol to prevent miscarriages 20 years after the drug was proved useless in treatment. Prescribed usage ceased only after the FDA intervened, and for an entirely different reason—researchers discovered that silbesterol caused cancer in the daughters of women who used the drug during pregnancy.

Obviously, the breadth and quality of medical care hinge on what happens in medical school. Too few medical students opt for general practice. Too many become specialists. The emphasis is on cure rather than prevention.

As users of health care services, women have a great stake in changing the system. It is *our* responsibility now—present administrators have shown that they can't do the job. In most health care matters, women are the decision-makers for their families. We are the system's largest (and least willing) financial backers, as well as its most severely abused victims. In its present state, the American system of health care does not work

well for consumers, particularly female consumers. Its inefficiencies waste money and manpower and drive up costs. Its lack of availability leaves many people with little or no care at all.

THE SOLUTION: HEALTH SECURITY

There are many proposals for national health insurance that attempt to patch up the present system. But only the Health Security Program offers genuine reforms. It establishes the principle of health care as a right. Individuals regardless of their sex or their age pay equal amounts and are entitled to full and equal benefits.

It also provides for meeting health personnel needs and makes care available to all with cost and quality controls, efficiency of delivery, and consumer participation in the program policy and administration.

Health Security would pay for all hospital and physicians services, as well as for eyeglasses, hearing aides, dental services for children, mental health treatment, preventive and rehabilitative care. There would be no co-insurance, no deductibles, and you'd never see a bill.

Health Security would be paid for by a payroll tax of one percent on salaries up to $24,750 per year. It would replace the one percent deduction now scheduled to finance Medicare, and present private health insurance premiums. In other words, it would rechannel existing health insurance costs. The program would be administered by a Health Security Board.

Employers would be asked to contribute three and a half percent of payroll, which is less than many are now paying in private health insurance premiums. Self-employed persons would pay two and a half percent of income up to $24,750 a year. The Federal government would match the collected funds.

Health Security would replace Medicare, *most of Medicaid* and many other health programs now paid for by the Federal government.

Cost and quality controls are built into the proposal. The program would set limits on fees and require approved hospital budgeting. Other institutions would also require budget approval for payment. It would encourage the use of outpatient care rather than hospitalization for tests and other treatment. Group practice and Health Maintenance Organizations would be developed through grants, loans and incentives.

In a Health Maintenance Organization or group practice, it is clear that consumers spend one-third to one-half less time in hospitals and undergo 40 per cent less surgery. Because the services are prepaid, consumers use checkups and screening services. Doctors, who are prepaid, have incentives to keep people healthy. Group practice provides effective peer review and has a significant effect on improving the quality of care delivered.

A study in 1968 comparing the number of female surgeries under Blue Cross-Blue Shield with those under a prepaid group practice plan indicated that 9.2 hysterectomies per every 100,000 patients were performed under Blue Cross-Blue Shield compared to 4.8 performed under group practice.

In a group practice situation, doctors can see more patients per day and therefore make more health care available. Health Security also plans to provide money for recruitment and training of more professionals and medical technicians.

The program would also give consumers a voice in deciding how the health system will work.

Grants would be given to local non-profit agencies to develop and provide social care services to help care for people in their own homes instead of in nursing homes.

Nursing home care would be fully covered if the facility is hospital owned and operated and the care is covered by the hospital's budget. Psychiatric care would be encouraged, as would use of prescribed drugs needed for costly illnesses.

Emphasis would be placed on preventive services and screening procedures, vaccines, prenatal care, check-ups.

The Health Security Program would assure quality health care for all Americans on an equal basis.

CNHI

Committee for
National Health Insurance

821 15th St., N.W. • Washington, D.C. 20005

A Comparison of Major National Health Insurance Bills in the 95th Congress

Prepared by **Committee for National Health Insurance**

As of June 1977

LEGISLATIVE PROPOSAL	PRINCIPAL CONGRESSIONAL SPONSORS & ENDORSEMENTS	CONCEPT	COVERAGE	BENEFIT STRUCTURE	FINANCING	COST CONTROL REIMBURSEMENT OF PROVIDERS	QUALITY CONTROL	HEALTH DELIVERY AND RESOURCES	ADMINISTRATION
HEALTH SECURITY ACT S.3 HR 21	Representative Corman (D-Calif.) Senator Kennedy (D-Mass.) Committee for National Health Insurance AFL-CIO Church Groups Senior Citizens Consumer Groups Health Professionals	Universal, federalized comprehensive health insurance plan with provisions for reorganization of the health care system and development of health resources.	Covers all U.S. residents. Medicare repealed; Medicaid retained in part to cover services beyond benefits provided.	Benefits cover the entire range of personal health care services including full prevention and early detection of disease without coinsurance, deductibles or waiting period. Initial limitations on adult dental care, psychiatric care, long-term nursing home care and drugs with planned phase-in. Grants to develop social care services to aid chronically ill, aged and other homebound patients.	50% from general tax revenue and 50% from a 3½% tax on employer payroll, a 1% tax on the first $24,750 a year in wages and a 2½% tax on the first $24,750 a year of self employment income and non-earned income all to be administered through a Health Security Trust Fund. All payments to private insurers by employers and individuals would be eliminated.	Operates on annual national budget, regional budget, prospective budgets for hospitals and other institutions, negotiated budgets for prepaid group practices and negotiated payments to physicians in solo practice charging on a fee-for-service basis. Providers barred from making additional charges to individuals for services performed within the system.	Mandates quality control commission and national standards for participating professional and institutional providers. Regulation of major surgery and certain other specialist services; national licensure standards and requirements for continuing education.	Health Resources Development Fund established for improving delivery and increasing resources with emphasis on development of various forms of prepaid group practice plans. Provisions for encouraging more efficient organization of existing health manpower, and of training and retraining of health professionals.	Publicly administered program in Department of HEW, five-member, full-time Health Security Board appointed by the President. Ten HEW regions, 200 sub-regions. Advisory councils at all levels with majority of members representing consumers. Local ombudsman groups used as sounding boards for consumer problems.
HEALTH SERVICES ACT HR 6894	Representative Dellums (D-Calif.)	A Health Bill of Rights guaranteeing access to all health services, choice of facility, choice of provider, and explanation of procedures in one's native language. Specific protections are designed for women, children and institutionalized individuals to ensure their special situation and health needs are met.	All United States residents.	Benefits cover, without charge, a full range of medical, dental and psychiatric services as well as home health, midwifery, occupational health, and educational services. These are to be provided in facilities established and maintained by a National Community Health Service (NCHS).	Special health service tax on individual and corporate incomes in addition to contributions from general revenues. The health service tax would be steeply progressive, and general revenues would contribute sums currently spent by Federal, state and local organizations for health services.	Funds to be distributed to providers on a uniform, per capita basis. Special funds allocated to communities for care of persons over 65 years of age and others with special conditions. The district health boards would determine the division of funds between the district and community levels, requiring the consent of a majority of the community health boards in each district. Similar procedures would be followed in dividing funds between the regional and district levels, and the national and regional levels. All health boards would have an equal part in determining the allocation of funds.	There is an elaborate system of checks and balances. Members of health boards would be accountable to people who elect them and the boards that appointed them, and regional health boards would be empowered to investigate complaints regarding the mismanagement of funds and develop advanced specialty programs.	The first priority for health research in the NCHS would be the prevention and correction of the leading causes of illness and death, including environment, occupational, and social factors. Research would be performed, to the maximum extent possible under the auspices of community and district boards, to ensure that it was responsive to the health needs of particular segments of the population. The work now sponsored by the National Institute of Health would be similarly decentralized, and several new institutions would be created to examine the symptoms and cures of illnesses.	The NCHS would be set up as a four-tier system—the community, district, region and nation. *Primary care would be provided by community health organizations. Several communities would be joined together to form a district, which would have a general hospital and a health team school where all health workers would receive their education. Several districts would form a region, each having a medical center providing specialized medical services.* At the national level, there would be national research and administrative facilities. Anyone who is 18 years of age or older, and has knowledge of health care problems is eligible to serve as a member of the interim board of directors.
THE NATIONAL HEALTH CARE ACT OF 1977 HR 5 S 5	Representative Burleson (D-Texas) Senator McIntyre (D-N.H.) Health Insurance Association of America	A voluntary approach based on federal income tax incentives for employees and employers to encourage purchase of a minimum package of approved private health insurance, through (1) employer or (2) individual (private) plans and (3) grants to states to buy insurance for the poor and the uninsurable through a state insurance pool (state plan). Includes minimal provisions to improve health care delivery.	Voluntary for all U.S. residents. Medicare continued; Medicaid covers services beyond benefits provided. Consumer could refuse to purchase. Non-citizen residents would not be eligible.	To be phased-in in two stages with maximum deductible of $100 and coinsurance of 20% with a maximum annual out-of-pocket expense per family per year of $1,000 with exceptions of mental health and dental benefits. In 1977 benefits would include unlimited hospital inpatient and outpatient physical and psychiatric care; physicians' services; 20 outpatient mental health visits; prescription drugs and contraceptive devices; 180 days of skilled nursing and 270 days home health care; certain oral surgery; well-child care. In 1985 coverage for very specific dental care, physical and speech therapy, eyeglasses and periodic physical examinations would be covered.	Complex provisions for purchase of private insurance based on three categories of beneficiaries: (1) employees, (2) individuals, and (3) state health care plans for the poor and near poor. In total a beneficiary can fall into one of 27 categories. Employer-plan: shared premiums for purchase of private policies; low income employee contributions limited according to wage level. Individual plan: enrollee pays full premium. Federal income tax deduction for employers and enrollees equal to full cost of premium payments for approved insurance; no tax deductions for unapproved plans. State plans: enrollee premium contributions based on income and family size; balance paid with state and federal general revenues through a state insurance pool. Federal share ranges from 70% to 90%.	Payments to institutions based on prospectively approved rates, by category of institution. State commission approves budgets and charge schedules on basis of reasonable charges, subject to HEW review. HMOs paid on per capita basis. Physicians paid on reasonable charges not exceeding customary and prevailing rates.	Except for meeting Medicare standards and regulations to be established for HMOs, no provision for quality control.	Emphasis on creation of outpatient care centers through grants, loans, and loan guarantees. Loans and grants for health manpower development, with priority to shortage areas. Option to join HMOs to be available under all plans. Provisions to strengthen health planning, with increased funds and authority to state and local planning agencies. Presidential Health Policy Board set up to advise on planning and conduct research.	For the private plans, state insurance departments approve policies and monitor financial operations of private carriers. Treasury Department rules on tax status of plan. For state plans, HEW sets standards for operation of plans; state insurance departments supervise the operations. Thus, state insurance departments become the administrators.
COMPREHENSIVE HEALTH CARE INSURANCE ACT OF 1977 S 218 HR 1818	Representative Carter (R-Ky.) Representative Duncan (R-Tenn.) Representative Murphy (D-N.Y.) Senator Hansen (R-Wyo.) American Medical Association	Mandates employers to offer qualified private health insurance to employees and families. Federal cash subsidies or tax credits to employers if program increases total payroll costs by 3% or more. Federal assistance via tax credits for non-employed and self-employed.	Voluntary acceptance of coverage by employees, non-employed and self-employed. Medicare population eligible for benefits equal to those for the general population. Health Insurance for the unemployed.	Inpatient and outpatient hospital care services, 100 days in skilled nursing facility, diagnostic, therapeutic and preventive medical services, home health services, dental care for children 2 through 6, and emergency dental services and oral surgery for all. 20% coinsurance for all services with limits based on family income and ceilings of not more than $1,500 per individual and $2,000 per family.	Premium payments of at least 65% by employers and the rest by employees if they chose to participate. Federal assistance to employers whose payroll costs increased more than 3% because of the program, ranging from 80% of the excessive increase during the first year to 40% in the fifth year. Federal assistance in the form of tax credits for health care insurance for non-employed and self-employed individuals and their families. Amount of federal assistance scaled according to tax liability.	NONE	Amendments to PSROs to make them more responsive to Medical Societies.	Establishes Office of Rural Health within HEW to award grants, contracts, loans and loan guarantees for projects pertaining to rural health care delivery. Otherwise, no changes in present system.	A 15 member Health Insurance Advisory Board consisting of the Secretary of HEW, the Commissioner of Internal Revenue, six M.D.s, 1 D.O., 1 D.D.S., and the remaining five appointed by the President from the general public to prescribe regulations and Federal standards for States' Insurance Departments and review effectiveness of the programs.
LONG-RIBICOFF CATASTROPHIC HEALTH INSURANCE AND MEDICAL ASSISTANCE REFORM ACT (as introduced in the 94th Congress) S 2470 HR 10028	Representative Waggoner (D-La.) Senator Long (D-La.) Senator Ribicoff (D-Conn.)	Three-part federal program providing (1) catastrophic coverage for all, (2) a medical assistance plan with basic benefits for the poor and medically needy, and (3) voluntary program for certification of private insurance to cover basic benefits.	Catastrophic coverage: all U.S. residents covered by private carriers or by Social Security. Medical assistance plan: all persons now receiving Medicaid plus others meeting certain income limits, varying according to family size, who are considered medically needy. Medicare continued; Medicaid federalized.	Catastrophic plan: all medical bills after out-of-pocket expenses reach $2,000 per family; all hospital costs over 60 days per person. Medical assistance plan: Hospital, skilled nursing, and intermediate facility care; home health services; physicians services; x-ray and laboratory; medical appliances; prenatal and well-baby care; family planning; periodic screening, diagnosis and treatment to age 18; inpatient mental health care in community health centers. Copayments of $3 for each of first 10 visits to doctor per family. Certified private plans must provide coverage for pre-catastrophic costs with limits on cost sharing.	Catastrophic: 1% increase in Social Security payroll taxes on employers who do not elect to purchase catastrophic insurance from private carriers. Medical assistance plan: general federal revenues with state contributions.	Loose guidelines as under Medicare. Payments must be accepted as payment in full under medical assistance program.	Same as under Medicare, including Professional Standards Review Organizations (PSROs).	Same as Medicare; provides for HMO option.	Through Social Security Administration. HEW Secretary certifies private plans in voluntary program, based on adequacy of coverage, conditions of eligibility, and availability. Insurers not offering certified policies ineligible to serve as Medicare carriers or intermediaries.

(11/77)

C·H·A·N

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Update: House Markup

On March 6 and 7, the House Health Subcommittee "marked up" (amended and approved for full Commerce Committee action) H.R. 10460. Pro-consumer amendments offered by Congressman Andy Maguire (D-N.J.) and supported by the Consumer Coalition for Health and other consumer groups were accepted. One makes clear that all HSA committees and other advisory groups must have consumer majorities. Another requires that at least one member of the HSA staff be as-

(continued on page 4)

HSA Board Regs On Again? Late Again?

As a result of heavy pressure by the Consumer Coalition for Health and local health care organizations, it appears that HEW will issue regulations on HSA governing bodies, or at least so says Hale Champion, number two person in HEW. Testifying before Senator Kennedy's Health Subcommittee on February 1, Champion promised the regulations would be out by "the end of the month." February has come and gone, and still no regulations. Our sources say they are being worked on and will be out "soon."

Help speed them up. Write to Undersecretary Hale Champion, HEW, Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201, urging that the regulations be issued promptly, that they ban self-perpetuating HSA boards and that they provide that persons outside a group can represent the group only if nominated by an organization composed primarily of members of the group to advance its interests.

News from:
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Ted Bogue, CHAN Editor

HEALTH PLANNING AMENDMENTS

Bills Amending Planning Act

The following bills containing amendments to the National Health Planning Act have been introduced in Congress and were the subject of the hearings described in the accompanying story.

H.R. 10460, sponsored by Congressman Rogers, Chairman of the Health Subcommittee of the House Commerce Committee, includes the following major amendments of interest to consumers.

1. Unions are required to be represented as "major purchasers" on HSA boards. Unfortunately, former "indirect providers" such as hospital trustees would immediately become consumers rather than having to wait for a year.
2. Self-perpetuation of HSA boards (present members selecting new members) would be completely banned, and broad public participation in the selection process is required.
3. HSAs which are counties or cities would be allowed to have the entire HSA board appointed by local elected officials--certainly a step backward.
4. One provision would extend the requirements for open meetings, public notice, and disclosure of data to the executive committee and all other HSA committees.
5. Each HSA would be required to provide assistance to members of the HSA board and other committees, including training and continuing education.

(continued on page 5)

Consumers Testify at Hearings

Several consumer groups testified at House and Senate hearings on bills which would amend the National Health Planning Act (see accompanying story for details on the bills) during the week of January 30-February 3. Appearing on behalf of the CONSUMER COALITION for HEALTH were President Herb Semmel; Anne Fenerty, consumer board member of the Central Northeast Colorado Health Systems Agency in Denver; Barry Checkoway, organizer of the Champaign County Health Care Consumers; and Steve Suitts, Executive Director of the Southern Regional Council in Atlanta. Dr. Sidney Wolfe and Ted Bogue testified for the HEALTH RESEARCH GROUP. Several legal services clients and their attorneys testified on behalf of the legal services programs in Georgia, Atlanta, and New Orleans and the NATIONAL HEALTH LAW PROGRAM.

Herb Semmel, speaking for the COALITION, emphasized that "the question of control of the health planning process is the most fundamental decision facing Congress. Is the health planning process going to end up as just another case in which those interests which are supposed to be regulated actually control the regulators?" He sharply criticized the failure of HEW to either enforce the "broadly representative" of the population

(continued on page 4)

Indiana HSA Sues

An Indiana lawsuit raises the issue of whether HSAs can challenge State agencies which arbitrarily reverse sound local planning decisions. In an earlier CHAN (April 1977, p. 5), we reported a similar State reversal of a decision against hospital expansion by the Dayton, Ohio HSA. In that case, the local Blue Cross has stood by its policy of not contracting with a new hospital not approved by the HSA, despite State and Federal approval. Also, Health Resources Administrator Henry Foley wrote to the Ohio health director, questioning whether, in light of this decision, Ohio can meet Federal certificate of need standards.

In August 1977 the Southern Indiana HSA disapproved a certificate of need application for a CAT scanner submitted by Welborn Hospital in Evansville, which already had two scanners, one of which hadn't even been installed. The State Health Commissioner --without consulting the Executive Board of the State Board of Health, the designated 1122 planning agency-- approved the application, reversing the HSA. The decision was inconsistent with the state CAT criteria, calling for full utilization of existing scanners, which had been followed by the HSA.

The HSA requested a State administrative appeal pursuant to P.L. 93-641 and was denied. It then filed suit in state court against the State Board of Health and the Hospital. On February 7, the Court ruled that only the applicant and not the HSA had the right to appeal a State agency decision under 1122 regulations. Indiana has no state certificate of need statute yet and therefore the Federal 93-641 regulations giving the HSA appeal rights were held not to apply. The HSA had also taken an administrative appeal to HEW, which said it had no basis for overturning the State decision. The HSA is considering whether to appeal the decision to an Indiana appellate court. This case illustrates an unfortunate lack of consumer control over State health planning agencies.

For further information, contact Carl Ahrens, Executive Director, Southern Indiana HSA, 1602 I Street, Bedford, IN 47421, phone (812) 275-5984.

Denver HSA Abuses

In the August 1977 CHAN (p. 4), we reported on the formation and early activities of the Colorado Health Research Coalition. More recently, the Coalition and other Colorado consumer organizations have directed their efforts at exposing and correcting abuses in the Central Northeast Colorado (Denver area) HSA.

There are serious problems with the performance and composition of the existing board and staff. Because of resignations by many frustrated consumers, the governing board has had a provider majority since early 1977. Also, non-institutional providers and low-income consumers are under-represented. Board members' requests to staff for information and documents, even those as important as an application for renewed funding, have been denied. As a result, little substantive work is being done; plan development is 9 months behind schedule. On the other hand, the board approved three contracts totalling more than $100,000, one to a firm with ties to the HSA Executive Director, in 10 minutes. Ill-advised decisions can be partly attributed to extremely inadequate board training by either HSA staff or the Denver regional center for health planning.

The HSA's record in involving the public in its activities is equally abysmal. The Board is almost entirely self-perpetuating. Consumer groups and state and local public officials, who have also been excluded, have repeatedly and publicly criticized the HSA for making no effort beyond legal notices of meetings to reach out to community groups. The HSA seems to have concentrated its efforts on getting favorable publicity in an NBC-TV documentary on health care.

The Health Research Coalition, the Gray Panthers, and other consumer and public official groups have been attacking the HSA for nearly a year, through unfavorable press coverage, informing the Colorado Congressional delegation, and complaining to the HEW Regional office, which is supposed to oversee the HSA. Their efforts have recently borne some fruit. After a new official was installed in the Regional Office (previously, an HEW official was quoted as saying "I don't care what [the HSA does] with the [Federal] money" and that consumer board members who complained were "dissidents") an HEW Site Assessment was done which confirmed the criticisms made by consumers and cited 79 major deficiencies. Colorado Congressman Tim Wirth has recently written HEW Secretary Califano opposing full designation of the HSA until the deficiencies are corrected. The Coalition and other consumer groups are trying to stop full designation (scheduled for July 1) and are developing an alternative model for a truly publicly accountable HSA. It appears that the HSA will not be fully designated until major reforms are made.

For further information, contact Gene Aldridge, 430 E. 11th Avenue, Suite 105, Denver, CO 80203, (303) 837-0077, or Anne Fenerty, 2805 Stanford Avenue, Boulder, CO 80303, (303) 494-8562.

CCH Executive Search

The Consumer Coalition is seeking an Executive Director. The position is presently funded for only six months, but additional funding is anticipated. The Executive Director will be responsible for organizational activities, fund-raising and development of substantive policy recommendations. Applicants combining health and organizing backgrounds are particularly sought. Persons from both sexes and minority groups are encouraged to apply. Send resume to Herbert Semmel, President, Consumer Coalition for Health, 1511 K Street, N.W., Suite 220, Washington, D.C. 20005. Please do not call.

Coalition Board Members Elected

The voting for initial members of the Consumer Coalition for Health Board of Directors is now complete. All 21 candidates for organizational board members were elected. On contested seats the following members were elected:

Individual Members (5): Charles Conrad, Shirley Flaherty, Elma Griesel, Kathleen Ittig, and Herbert Semmel.

Provider Representative: Jeffrey Cohelan, Group Health Association of America (Washington, D.C.).

HSA Representative: Sandy Smoley, Golden Empire HSA (Sacramento, California).

The complete list of Board members is being mailed to all Coalition members, together with an announcement of the time and place of the first meeting.

M.D.s: 1, HSA: 0

In case you have any lingering doubts about whether physicians view HSAs as a threat to their dominance of the health care system, consider the following. The 6400 members of the Fairfield (CONNECTICUT) County Medical Association were each assessed $100 to hire full-time staff to monitor the activities of the Southwest Connecticut HSA, including attending every general meeting, task force meeting, and review committee meeting. The Association staff mobilized public opinion against the HSA's Health Systems Plan through a well-financed anti-HSA advertising campaign and packing public hearings, which led to amendments to the HSP and the above headline in the AMA News. Local residents were led to believe that the Federal government was going to close pediatric beds and set up abortion clinics. The HSA has now softened their calls for performing surgery on an outpatient basis and consolidating services. Provider advocacy is alive and well in Connecticut.

HEW Criticizes Memphis HSA

In the August 1977 CHAN (p. 5) we reported on the formation of the Memphis Coalition for Quality Health Care to monitor the local HSA and improve access to necessary care in the Memphis area. After several months of criticizing the Mid-South Medical Center Council (MMCC), the area HSA, the Coalition's efforts began to bring results. In response to a detailed formal complaint filed in August 1977 by a local legal services lawyer with the HEW Regional Office in Atlanta, MMCC was investigated on-site by HEW in November 1977. In addition, a local county-city watchdog agency issued a critical report on the HSA triggered by complaints made by the Coalition and other consumers at public hearings. The local report was released to the press in February at the same time as the findings and recommendations from the HEW investigation.

Both reports confirmed the major charges made by the Coalition. HEW found that MMCC had "a closed-shop atmosphere" and "didn't pay attention to the needs of the community." It also found that the MMCC Executive Director "intimidated" persons who opposed him. The city-county report found MMCC to be "anti-government and anti-consumer" because of its domination by large private Memphis hospitals. HEW recommended that MMCC continue to increase the number of low-income persons, women, and elderly on its Board, better orient its board members, and make information, meetings, and staff more publicly accessible. The county-city report recommended removal of the Executive Director, contracting with the Coalition for consumer education, and conditioning full designation on re-constituting the Board and other reforms.

Though the MMCC, thanks to the Coalition's monitoring, has become somewhat more publicly accountable in recent months, Memphis consumers are concerned about reports that the MMCC will soon receive full designation. For more information contact Donald Donati, Memphis and Shelby County Legal Services, 325 Dermon Building, 46 N. 3rd Street, Memphis, TN 38103, phone (901) 526-5550.

Citizen Nursing Home Reform Coalition

The National Citizens Coalition for Nursing Home Reform is composed of citizen and nursing home resident groups which are advocating improved quality of care in nursing homes at the state and local level. The Coalition was formed in 1975 at a meeting of representatives of the Gray Panthers, citizen groups, and nursing home ombudsman programs, who agreed to work "to strengthen the mechanisms through which we can hold all participants in the system accountable: the industry, including non-profit facilities; the regulatory agencies; and, community religious, social service and educational institutions which have generally turned their heads away from this issue."

A national symposium on strategies for action was held in Kansas City in May 1977. The National Steering Committee of the Coalition met in February 1978 with HEW officials to urge the tying of nursing home reimbursement to quality of care, improving enforcement of nursing home standards, stopping moves to turn nursing home inspection over to the industry and the Joint Commission on Accreditation of Hospitals, mandating training for nurses' aides in nursing homes, and increasing citizen participation in decision-making.

Coalition members recently completed a report called "The Plight of the Nurses Aide in America's Nursing Homes: An Obstacle to Quality Care for Nursing Home Residents." All members receive "Collation," a periodic newsletter with local, state, and national news and resources on nursing home reform.

For more information on Coalition activities and how to join, contact Elma Griesel, Program Coordinator, 2000 P Street, N.W., Washington, D.C. 20036, phone (202) 872-0655.

HEARINGS (continued from p. 1)

requirement for HSA boards or to issue promised regulations defining the term. Mr. Semmel presented the legislative platform developed at the December Coalition meeting (see January CHAN), with emphasis on board selection and composition and consumer education.

Mr. Semmel and other consumer witnesses supported several consumer-oriented amendments. However, he stressed the failure of the bills to address adequately the lack of responsiveness of HSAs to consumer concerns. There was no effort to amend the statutory language requiring the consumer component of HSA governing bodies to be "broadly representative" of the area population so that low income families, women, the handicapped, and the elderly would be adequately represented. (There may still be HEW regulations on this subject, however. See story on p. 1). Though the bills include language about training and assistance for HSA board members, a major consumer education effort is not required.

Barry Checkoway, Assistant Professor of Urban and Regional Planning at the University of Illinois, described a study of the East Central Illinois Health Systems Agency done by several students under his direction (for more information about the report, see the August 1977 CHAN, p. 5). The failure of the HSA to represent low-income people and women, or to encourage public involvement led to the formation of the Champaign County Health Care Consumers (see story in the November 1977 CHAN, p. 5) to monitor and reform the HSA. Mr. Checkoway stressed the unresponsiveness of the HEW bureaucracy to the criticisms in the report and the impending full designation of the HSA, despite its deficiencies.

Anne Fenerty of Boulder, Colorado, presented testimony regarding serious problems in the Denver area HSA. (See the story on page 2 for more details and an update).

Steve Suitts, Executive Director of the Southern Regional Council, told the Subcommittees about the Council's study of health planning in 28 HSAs and 11 State Agencies in the South. (The report, "Placebo or Cure? State and Local Planning Agencies in the South" is described in the August 1977 CHAN, p. 4). Mr. Suitt's testimony concentrated on the general failure of Southern HSAs to represent and reach out to those groups in the community, particularly low-income families, minorities, and women, whose lives are most affected by health planning decisions.

The HEALTH RESEARCH GROUP submitted both oral and written testimony to the subcommittees which endorsed the amendments proposed by Coalition members and called for a full-time consumer staff independent of the HSA providers and Executive Director with a substantial budget, which would be responsible for consumer training, community outreach, etc. HRG also urged that State Agencies have consumers majorities with fixed terms, that certificate of need loopholes for Federal facilities and medical equipment be closed, that hospital construction be halted until State Agencies are fully designated, and that consumers be given appeal rights.

Clients of legal services lawyers submitted extensive testimony to both the House and Senate Subcommittees. Low-income clients, lawyers, and a paralegal gave oral testimony at the hearings. In addition, the NATIONAL HEALTH LAW PROGRAM submitted documentation of abuses and problems in the health planning process gathered in a 40 state survey of the experiences of legal service clients and lawyers with health planning agencies. Several of the witnesses from Georgia and the New Orleans area had been directly involved in litigation and consumer organizing concerning the selection and composition of HSA boards (see August 1977 and January 1978 CHANs). The testimony emphasized the exclusion of poor people from the health planning process and the consequent failure of HSAs to address problems of quality and access by low-income and minority patients.

"PROFITS IN HEALTH CARE" Bill Plympton/Health PAC

UPDATE (continued from p. 1) signed responsibility for giving consumer board members "such assistance as they may require to effectively perform their functions." Finally, an amendment which makes accessibility to patients a required criterion for all HSA reviews will help protect low-income people and racial minorities from discrimination and service cutbacks due to relocation of hospitals from city to suburbs.

On the other hand, several other amendments were extremely detrimental to consumer interests. Health insurers, often controlled by hospital and physician groups, were reclassified as "consumers," effectively nullifying the consumer majority requirement. (However, the provision allowing HSAs to accept funds from health insurers was deleted.) Chairman Rogers caved in to Dr. Tim Lee Carter (an M.D. and ranking Republican on the subcommittee) on an amendment which effectively deleted coverage of major medical equipment in private physician offices. In public HSAs, elected officials can disapprove the HSA Board's Health Systems Plan. The complete ban on self-perpetuation of HSA boards was modified so that up to 1/2 of consumers and 1/2 of providers could be appointed by other board members who were publicly selected. The Coalition wanted appointed members limited to 1/3.

BILLS (continued from p. 1)

6. Certificate of need coverage is extended to major medical equipment (costing more than $150,000) in all settings, including physician offices--a major improvement. The establishment of outpatient facilities by Health Maintenance Organizations would not be covered.

S. 2410, sponsored by Senator Kennedy, Chairman of the Health Subcommittee of the Senate Human Resources Committee, includes the following amendments not in or different than those in H.R. 10460:

1. HSA boards would be required to have representation from non-professional health workers. However, people who sit on the boards of directors of hospitals or drug companies would be classified as consumers.

2. HSAs would be allowed to accept funds from any organization with a "501(c)(3)" tax exemption, which unfortunately includes foundations supported by providers.

3. The Governor is given veto power over the State Health Plan, a step which will compromise the political independence of state health planning.

4. HEW would be allowed to return fully-designated HSAs to conditional status for poor performance, a power which could provide HSAs with incentive to perform better.

5. The regional back-up Centers for Health Planning would be required to develop methodologies for educating HSA board members.

H.R. 11077 (bill submitted by HEW). HEW has taken the position that the health planning program should be kept "intact" so as not be disrupt the activities of HSAs and State Agencies. Its proposed amendments, however, include several of the changes sought by state and local officials, such as direct control by counties or cities over public HSAs and approval of the State Health Plan by the Governor (amendments also included in the House and Senate bills). On the other had, amendments which would increase and improve consumer involvement in HSAs, such as requirements for open board and committee selection and composition and assistance to consumers, are totally absent from the bill. Not even the limited consumer-oriented changes proposed in the House and Senate bills are included. Thus, HEW has chosen to be responsive to the interests of public officials and ignore the interests of consumers.

Health Planning Guidelines Revised

In the January CHAN we reported on the furor caused by the issuance of proposed national health planning guidelines containing standards on hospital beds and obstetrical units, widely misinterpreted to mean that HEW was going to close small hospitals and maternity wards in rural areas. No standards on access to primary and emergency services in underserved areas were included. Revised guidelines, still in proposed form, were published on January 20 (43 Federal Register 3056) for public comments. Final publication of the guidelines, which are unlikely to undergo any further significant changes, is expected in mid-March.

The major change in the January 20 version is the addition of a broad "general adjustments" clause which allows HSAs to justify deviations from any standard when none of the specific exceptions under individual standards applies. Adjustments are required for Federal facilities and HMOs and permitted for "access to necessary health services," increased costs of care, and "special needs resulting from moral and ethical values." In addition, Health Systems Plans will not be reviewed by HEW for compliance with the guidelines except as one factor in periodic evaluations of performance. In short, any HSA or state agency which does not follow the guidelines will not be forced to do so by HEW. The requirement in P.L. 93-641 that HSPs be "consistent with" the national guidelines would be deleted if an amendment just approved by the House Health Subcommittee becomes law. (For a copy of HRG's comments on the January 20 guidelines, send 50 cents and a stamped, self-addressed envelope to HRG and request publication #521.)

HEW Changes Policy on CATs

On December 21, 1977, the Health Research Group wrote HEW Secretary Califano, urging him to close loopholes in Federal health planning and capital expenditure review regulations which were allowing the unregulated purchase of CAT scanners costing less than $100,000. (For a copy of the letter, publication #513, send a self-addressed, stamped envelope and 55 cents to HRG.) HRG recommended that HEW interpret regulations under both P.L. 93-641 and section 1122 to cover all CAT scanner purchases, regardless of initial cost or location, because of their major impact on operating costs. Further, HEW was asked to refuse to provide Medicare reimbursement for future scanner purchases and to urge a moratorium in the national health planning guidelines, since more than 1000 scanners, many of them duplicative, have already been installed or approved in the U.S.

On February 3, 1978, the HEW Health Planning Bureau issued instructions to HSAs and State Health Planning Agencies interpreting section 1122 regulations to require review of all scanners as a "substantial change in services," whether or not there is a capital expenditure exceeding $100,000. HRG subsequently wrote Harry Cain, Bureau director, supporting the policy change but expressing disappointment that it would apply only in 1122 states (non-1122 states include California, Illinois, Massachusetts, Missouri, and Texas).

Certificate of need regulations under P.L. 93-641, which apply to every state and also require review of new services as well as capital expenditures, were not given a similar interpretation. HEW has not acted on the recommendations for coverage of physician offices (though HEW supports a legislative amendment to this effect), a national moratorium, or refusal to Federally reimburse for new scanners

BRIEFS

For consumer-oriented information on nutrition, contact Nutrition Action, Center for Science in the Public Interest, 1755 S Street, N.W., Washington, D.C. 20009, phone (202) 332-4250. The monthly Nutrition Action magazine is $10/year. CSPI wants to work with local groups to integrate nutrition education into health planning activities.

HSAs Obtain Access to PSRO Data

Both consumer groups and health planning agencies have long complained about their inability to obtain data from Professional Standards Review Organizations (PSROs). In a Policy Statement on HSA/PSRO Relationships issued by HEW on November 29, 1977 (PSRO Transmittal No. 59) to all PSROs and HSAs, PSROs are instructed to comply with recent amendments to the PSRO law contained in P.L. 95-142, under which "PSROs are required to provide aggregate statistical data (without identifying any individual) on a geographic, institutional, or other basis reflecting the volume and frequency of services furnished. PSROs must implement this requirement immediately." The statement also says that, in any case where an individual institution is identified, the institution must be given 15 days to write comments on the data, which must be forwarded to the HSA with the data. However, the institution cannot prevent the PSRO from giving the HSA data which identifies individual hospitals unless it also identifies patients or doctors.

Unfortunately, PSRO data such as that which identifies individual physicians and data collected for medical care evaluation studies of quality of care still must be kept confidential by PSROs. The Health Research Group has sued the National Capital Medical Foundation (the PSRO for Washington, D.C.) and HEW under the Freedom of Information Act to obtain such data (U.S. District Court for the District of Columbia, Civil Action No. 77-2093, filed December 7, 1977).

The Religious Action Center (RAC) of the Union of American Hebrew Congregations is sponsoring An Educational Conference on Recombinant DNA and Genetic Research at the RAC, 2027 Massachusetts Ave., N.W., Washington, D.C. 20036, on Tuesday, April 11, from 9 a.m. to 4 p.m. The $5.00 registration fee includes materials and lunch. All interested persons are invited.

For more information contact Mindy Werner at RAC at the above address, phone (202) 387-2800.

The Occupational Health Program at the Harvard School of Public Health has completed a report for HEW's National Institute for Occupational Safety and Health called Planning for Occupational Health Needs in a Health Service Area. The monograph describes how an HSA can collect employment and health hazard data for an area profile of occupational health problems, coordinate with health personnel, unions, employers and government agencies, and develop strategies for prevention and control. Industry and employment data by health service area and a bibliography are included. Copies can be obtained from the National Technical Information Service, 5285 Port Royal Road, Springfield, VA 22161, phone (703) 557-4650, for $10.75 prepaid. Ask for publication number PB 274-077.

In the November 1976 CHAN, we reported on a study by the Oregon Student Public Interest Research Group (OSPIRG) called "The Rising Cost of Health Care," which documented the faults of health planning, particularly excess hospital beds, in the Portland, Oregon area. It included an analysis of past certificate of need decisions, the results of an area survey of hospital efficiency, and an outline of the health planning framework in Oregon. An updated report, released in December 1977, has new cost figures and information about the activities of the Northwest Oregon Health Systems Agency in Portland.

OSPIRG has publicly called for a moratorium on new hospital beds in the area and opposes the construction of a new Veterans Administration hospital.

For a copy of the report send $3.00 ($1.00 if you are an Oregon college student) to OSPIRG, 918 S.W. Yamhill, Portland, OR 97205, phone (503) 222-9641.

Join the Consumer Coalition for Health

Consumer Coalition for Health
1511 K Street, N.W., Suite 220
Washington, D.C. 20005
(202) 347-8088

Name of Organization or Individual Liaison Person

Address

City State Zip

Annual Membership Dues:

- ☐ $150 - National Organization
- ☐ $25 - Local Organization
- ☐ $75 - Health Systems Agency
- ☐ $15 - Individual
- ☐ $50 - Non-Member Correspondent

Organizational members are entitled to 5 free copies of each issue of CHAN, individual members one copy.
If you want 5 free copies, check here: ☐
If either individual or organizational members want additional copies, they are $.60 per copy per year (6 issues). No. of copies ____ Cost $ _____

C·H·A·N

Consumer Health Action Network

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Cain Resigns

Harry Cain, head of HEW's Bureau of Health Planning and Resources Development, which is responsible for implementing PL 93-641, announced his resignation at a widely-covered April 12 press conference. The resignation was unexpected and apparently not due to any pressure from his superiors in HEW. In explanation, Cain said "I have totally lost my tolerance for the bureaucratic swamp through which a bureau like this must wade." He complained of personnel problems and related delays in issuing regulations. He and other Bureau staffers have also been unhappy with intervention in the planning program from the HEW Secretary's office. In December 1976, the Health Research Group had called for Cain's resignation because of indecision, delay, and regulations with pro-provider loopholes.

Colin Rorrie, formerly Bureau Deputy Director, has been made Acting Director. He and others identified by a search committee to be established by Health Resources Administrator Henry Foley will be candidates to replace Cain.

PRESIDENT CARTER ATTACKS DOCTORS

Health consumer activists may have a new ally --Jimmy Carter. At a town meeting in Spokane, Washington on May 5, the President said that organized medicine has been "the major obstacle to progress in our country in having a better health care system in years gone by . . . I know that doctors care very seriously about their patients, but when doctors organize into the American Medical Association, their interest is in protecting the interests not of patients but of doctors." Unfortunately, the actions of his Administration have rarely lived up to this rhetoric.

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Ted Bogue, CHAN Editor

CIVIL RIGHTS & HEALTH PLANNING

INSTITUTIONAL RACISM AT HEW?

If one branch of HEW finds a hospital is violating Title VI of the Civil Rights Act by discriminating against minorities in admissions, can another branch give approval of a multi-million dollar expansion to the same hospital, thereby virtually guaranteeing the availability of federal funding to pay for the expansion? Of course not, you might say. But that is exactly what HEW was on the verge of doing when the threat of a lawsuit caused a delay. But the danger remains that HEW may engage in a classic demonstration of institutional racism -- denying minority rights through the application of "neutral" principles.

HEW's Office of Civil Rights has issued letters of findings that three New Orleans area hospitals, Ochsner, Mercy and West Jefferson are violating the civil rights laws by discrimination in admissions. But after these findings, the New Orleans HSA and the Louisiana SHPDA have approved applications by these hospitals for capital expenditures under Section 1122 of the Social Security Act. The matter is now awaiting decision by Dr. Henry Foley, Chief of HEW's Health Resources Administration.

In a meeting with civil rights attorneys Marilyn Rose, Jack Stolier and Herb Semmel (CCH President), Foley expressed concern about discrimination by health facilities but stated there were legal doubts about his authority to act. He said he had requested advice from HEW General Counsel Peter Libassi, and that is where the matter seemingly lies at present.

However, some insiders at HEW claim the Health Resources Administration wants nothing to do with civil rights issues, preferring to leave the matter to the Office of Civil Rights (OCR). But leaving it to OCR means that the discrimination will continue indefinitely. OCR is so understaffed and swamped with complaints that years go by before any action is taken. In the 14 years since passage of the Civil Rights Act, only three full investigations of health care facilities have been undertaken by OCR, and in each case it took a lawsuit against HEW to force the investigation. In New Orleans, the lawsuit was filed in 1970; it took 7 years before HEW finally issued its letters finding the hospitals in violation of the law. In the meantime, tens of millions of federal dollars flow to the offending hospitals. In fact, no health facility has ever lost a penny of federal money through the OCR "enforcement" process.

In practical terms, enforcement by OCR means delay, and delay is what the offending institution wants, for the status quo and the dollar flow continue. But if the Health Resources Administration would refuse to give final approval to proposed capital expenditures until outstanding civil rights charges are resolved, the shoe would be on the other foot. Now the delay acts as an incentive to hospitals, anxious to proceed with expansion or modernization, to clear up the civil rights

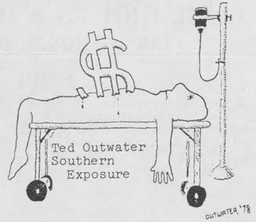
(continued on page 4)

Court Rules PSRO Data Disclosable

In the March 1978 CHAN (p. 6), we reported that changes in the Professional Standards Review Organization (PSRO) law required PSROs to make some hospital-identifiable data available to HSAs. Also mentioned was a lawsuit brought by the Health Research Group (HRG) against HEW and the PSRO in D.C. under the Freedom of Information Act (FOIA) to obtain data which identifies physicians and hospitals by name. On April 25, U.S. District Judge Gerhard Gesell ruled that PSROs are federal agencies for purposes of the FOIA and there fore subject to its broad public disclosure requirements. The court thus rejected HEW's long-standing policy of prohibiting public access to Medicare and Medicaid data which would show differences in quality among doctors and hospitals.

PSROs are groups of physicians which monitor for HEW the quality and medical necessity of Medicare and Medicaid services in local areas often coterminous with HSA areas. The public has never previously had access to information on individual providers of services from any source. Such data would enable consumers or HSAs to make comparisons among physicians and hospitals. For example, they could determine how frequently a physician performs medically unnecessary surgery or what a hospital's mortality rate for open heart surgery is.

The PSRO data will not be disclosed to the Health Research Group until the court determines whether any exemptions under the FOIA apply and an appeal has been decided.



Health Planning Amendments: Update

The Congressional bills amending the National Health Planning Act have now been ordered reported to the floor of both the Senate and the House of Representatives by, respectively, the Senate Human Resources Committee (S. 2410) and the House Interstate and Foreign Commerce Committee (H.R. 11488). Amendments favorable to consumers were approved by the full committee in the House and the subcommittee (and later the full committee) in the Senate. As reported, H.R. 11488 returns health insurers to the provider category (after Congressman Rogers was lobbied by the Consumer and labor groups). An amendment designed to prevent State Health Planning and Development Agency certificate of need decisions from being arbitrarily overturned by state legislatures was added to both the House and Senate bills. S. 2410 was improved by adding requirements for consumer majorities, open meetings, and disclosure of data which apply to all HSA committees, adding accessibility and quality as required criteria for all HSA reviews, requiring each HSA to designate one staff person to assist consumer board members, requiring the national guidelines to reflect the needs of underserved rural and other areas, and requiring representation of such areas on the SHCC.

Under S. 2410, another Senate bill which would amend the HMO Act, and recently proposed HEW regulations (43 Fed. Reg. 11229, Mar. 17, 1978), Federally qualified HMOs would be covered by certificate of need only for new hospital construction, unless the State also covers non-HMO ambulatory facilities.

However, the Senate bill (but not the House bill) still classifies hospital, nursing homes, and drug company trustees as consumers. The House bill fails to cover equipment in physician offices. In the Senate, deletion of such coverage was voted down 13-2. These differences will ultimately be resolved in a Conference Committee.

HEW "Citizen Participation"

On March 23, a notice seeking an HEW contractor to "organize and conduct a workshop on citizen participation in health care" appeared in the Commerce Business Daily (the document in which all government contracts are announced). Doug Engmann of the California Consumer Health Coalition was upset by the fact that it was clearly written for one pre-determined medical or public health school and was to be conducted by health professionals. Doug brought this to the attention of the Health Research Group and the Consumer Coalition for Health.

A few days later a letter signed by representatives of the Coalition, HRG, the California Coalition and the Cape Cod Health Coalition was sent to Henry Foley, HEW Health Resources Administrator, whose office had published the notice. The letter emphasized that the notice "smacks of continued paternalism and professional elitism" and that HEW still apparently believes "only health care providers can train consumers". It also sharply criticized the obvious institutional favoritism in HEW's approach.

The Coalition has been informed by HEW that the contract will be put up for bid. We were later told that the institution hadn't even proposed to do consumer education (contrary to the notice) but rather wanted to have a conference on theoretical studies of consumer participation. The Consumer Coalition for Health and other consumer groups are still waiting for a response to proposals made to HEW for funding consumer education projects.

HRG PUBLICATIONS

The Health Research Group has just reprinted its handbook on HSAs, Trimming the Fat Off Health Care Costs: A Consumer's Guide to Taking Over Health Planning. Copies are available prepaid for $2.00 per copy, $1.00 per copy for 4 or more. Also ask for the CHAN publications form which lists all HRG reports related to health planning, including those on CAT scanners, physician fees, hospital overbedding, etc. Send orders to: Health Research Group, Dept C, 2000 P Street, Washington, D.C., 20036.

Consumers Stop New York City HSA

On April 14, 1978, the Health Systems Agency of New York City, largest in the country in population covered and budget, was denied full designation by the New York Regional HEW Office. Instead, it was given an extension of conditional designation for another year, during which 18 listed conditions must be satisfied before full designation can be granted.

In March, the Ad-Hoc Committee for Public Accountability in Health, consisting of some of the individuals who were dissatisfied with the HSA, submitted to the HEW Regional Office a letter critical of certain HSA practices. These included selecting an Executive Director without a search process, failing to consider project review recommendations made by subarea councils, and dismissing subarea council staff over SAC objection. The Chairman of the Board of the Staten Island SAC also filed suit to enjoin HEW from processing the HSA's full designation application because the HSA had distorted the record of a public hearing before the SAC on the application.

The CONSUMER COALITION FOR HEALTH also sent a letter to HEW pointing out that the HSA had submitted no data to HEW on the incomes of board members, thereby making it impossible for HEW to determine whether the board was broadly representative of all economic groups, as required by PL 93-641.

Among the conditions attached to HEW's extension of the HSA's conditional status were a requirement that the HSA document within 30 days exactly how composition requirements were being met; a formal agreement specifying the executive director's duties, performance standards, and limitations, within 30 days, as well as a requirement that any new executive director be chosen according to procedures and criteria chosen by HEW; and a complete plan for the staffing and organization of the 33 subarea councils.

For further information, contact Laurence Snider (Chairman of the Ad-Hoc Committee), 131 Barrow St. #3B, New York, NY 10014.

MULTIPLE CHANS

In the January 1978 CHAN, we described how Coalition members could receive multiple copies of each issue mailed to one address. In order to verify our records, please let us know again if you want more than one copy. Any Coalition member which is an organization or a planning agency may receive up to 5 copies per issue for no additional charge. For individuals or for more than 5 copies for organization members, each additional copy is 60 cents more per year (6 issues). Use the application form on page 6.

PHYSICIAN FEES
HRG TESTIFIES

The Council on Wage and Price Stability recently published A Study of Physicians' Fees, which analyzes why physician fees and income have been rising much faster than general inflation. It is available from the U. S. Government Printing Office, Washington, D. C., 20402 for $3.25 (stock #041 001 00163 -8).

On April 5, the Health Research Group testified before the Oversight and Investigations Subcommittee of the House Commerce Committee on the rapid escalation of physician fees. Dr. Sidney Wolfe and Ted Bogue presented the results of two studies HRG had done on the Medicare physician reimbursement system. An examination of geographic variations in Medicare "prevailing" charges across the country had revealed differences in fees for four major surgical procedures of two or three to one after adjusting for cost of living variations.

HRG also looked at differences in Medicare and Blue Shield fees among individual, named physicians (now available from all local Medicare carriers under the Freedom of Information Act) in the metropolitan D.C. area and found equally large and unwarranted differences. HRG calculated that $6.79 billion per year could be saved under a national fee schedule. For a copy of the testimony, send a stamped, self-addressed envelope to HRG and ask for publication #531.

Other testimony from the Federal Trade Commission and other witnesses at the same hearings documented that Blue Shield insurance boards are usually dominated by the physicians from whom they buy services.

Western Mass. HSA Involves Consumers

When consumer groups insist on strict enforcement by HEW of the provision in P.L. 93-641 that consumers on HSA governing bodies be "broadly representative of the social, economic, linguistic, and racial populations, geographic areas of the health service area and major purchasers of health care," they are told it is impractical, if not impossible. Apparently, no one passed along this wisdom to the Western Massachusetts Health Planning Council (WMHPC). In a recent letter to CHAN, this HSA for 820,000 persons in a large geographic area described how it has involved over 2000 people in the shaping of its Health Systems Plan and maintained over 36 committees comprised of over 500 volunteers while carefully balancing its Board and three active Subarea Advisory Councils by income, age, sex, race and geographic area. For example, there is just one consumer on the Board with a gross family income exceeding $25,000.

WMHPC's community involvement orientation grows out of a philosophy adopted in 1967 (as a CHP agency) which emphasizes social change, consumer "worthiness", decentralization and "publicness". Agency staff believe that the broad representation on WMHPC decision-making bodies has recently been reflected in such HSP/AIP goals as increased access to primary ambulatory care, making facilities and providers publicly accountable for how much they spend, and emphasis on health promotion, disease prevention, and consumer education. Objectives include sliding fee scales and hospital and physician directories. In short, community participation has improved performance, not been a barrier.

For further information, contact Janice Berger Finkelstein, WMHPC, 50 Interstate Drive, West Springfield, Ma. 01089, phone (413) 781-2845.

ORAL ROBERTS: 777, PLANNING: 0

In a religious vision, Oral Roberts, the internationally known faith healer, saw a $250 million medical complex including a 30 floor, 777 bed hospital, a 20 story research center, a 60 story diagnostic clinic, and the new Oral Roberts University Medical School. It was to be called the "City of Faith," occupying 80 acres adjacent to ORU in Tulsa, Oklahoma. In his fund-raising drive, Roberts asked for contributions of $7, $77, $777, etc. God had led him to believe that there would be "a breakthrough from heaven in '77," Roberts said.

The project was delayed, however, by the more mundane concerns of Oklahoma health planners, primarily the fact that the state 1122 plan lists Tulsa as already having an excess of 1000 hospital beds. The statewide Oklahoma Health Systems Agency (OHSA) twice voted overwhelmingly against the application. While Roberts appealed to the State health planning agency, the Oklahoma Health Planning Commission, the State Senate passed a resolution supporting the City of Faith. On April 26, the three State Commissioners, who had received 100,000 letters supporting City of Faith, voted unanimously to reject the negative recommendation of their staff and approve the application. The 11 member Tulsa Hospital Council is appealing the decision to the courts. ORU intends to argue that denial would violate Consitutional religious freedom.

HOSPITAL EXPANSION

ILLINOIS GROUP PUBLISHES GUIDE

CONSUMER GUIDE TO LOCAL HEALTH CARE PLANNING is available from the Association of Health Care Consumers (AHCC). Written by consumers, the book has an explanation of the Federal Health Planning Act and Health Systems Agencies. It also covers such topics as how to be heard at public hearings and meetings, how to participate in health planning boards and committees, and how to complain about local health care services. It explains how to form a health consumer organization in your community.

To obtain a copy, write to: Consumer Guide, Association of Health Care Consumers, 109 North Dearborn, Chicago, Ill. 60602. Members of the Consumer Coalition for Health can get the guide for the special low rate of $1.25 per copy. For others, the cost is $2.50 for individuals, $5.00 for staff and professionals, and $10.00 for organizations.

In January AHCC had opposed a proposed rate increase for Blue Cross/Blue Shield of Chicago because it had failed to comply with an Illinois statute passed in 1977 which required the Blues to undertake vigorous cost containment efforts by using its financial leverage over the providers it reimburses. On March 24, the Illinois Director of Insurance rejected the rate increase. The hearing officer in the case had recommended denial based on failure to comply with the 1977 law.

AHCC President Frank Giarrizzo claimed a major victory for consumers but cautioned that the ruling did not apply to all subscribers and that the Blues would try again later this year. For more information contact AHCC (whose members receive a monthly newsletter) at the above address, phone (312) 641-5766.

CIVIL RIGHTS (continued from p. 1)
violations.

Whether HEW is in good faith in opposing discrimination in health facilities will soon be seen. The Board of Directors of the Consumer Coalition for Health adopted a resolution, now before the membership for approval, urging full integration of civil rights considerations into health planning.

A legal memorandum submitted by the Center for Law and Social Policy and the NAACP Legal Defense Fund on the issue is available on request from the CCH office.

Atlanta Group Active

A small group of consumer-oriented providers and consumers called the Community Health and Monitoring Project (CHAMP) has been meeting for over a year to develop strategies for improving health care in the Atlanta area. A principal activity has been oversight of the Atlanta-based North Central Georgia HSA, which, together with the other five Georgia HSAs, has been sued for failure to comply with the board composition requirements of PL 93-641. Most of the "consumers" on the initial HSA Board were actually chosen by providers, nearly 2/3 of them by the local medical society. The Executive Director of the HSA was formerly a paid lobbyist for the Medical Association of Georgia. The HSA Executive Board recently rejected a committee recommendation that a moratorium be placed on new hospital beds, favoring voluntary restraint instead, despite the excess of at least 1500 beds acknowledged to exist in the area. CHAMP was recently successful in pressuring the HSA to accept the results of a neighborhood election in choosing a nominee for board membership.

CHAMP has also discovered that Fulton County, which includes Atlanta, has failed to use Federal funds for the WIC (women, infants, and children) program and, as a result, the state of Georgia may lose as much as $850,000 for the program.

CHAMP has monthly meetings and a monthly newsletter with a mailing list of 200. For further information, write CHAMP, 445 Clifton Rd., NE, Atlanta, GA, 30307 or call Henry Kahn or Dan Blumenthal at (404) 588-3593.

Arizona Center Helps Consumers

The Arizona Center for Law in the Public Interest is the only public interest law firm in the state of Arizona. It began in 1974 and now has a staff of 9 representing consumers in utilities proceedings, a nursing home advocacy program, and a developmentally disabled advocacy program. The Center is also the only group representing consumer interests before the Phoenix-based Central Arizona Health Systems Agency. It has appeared in several hearings to question unwarranted hospital construction and has explained the health planning process to several community groups. In one case, it appealed the HSA's approval of a hospital proposal because of ex parte (off the record) contacts between the hospital and HSA board members.

The Center recently applied to the Office of Consumer Education of the HEW Office of Education for a consumer health planning education project grant. It proposed to identify interested consumers inside and outside the HSA and increase their level of involvement, prepare a local consumer health planning handbook, develop a public information campaign, start a consumer newsletter, participate in certificate of need and rate request hearings before the HSA, and, finally, develop a local consumer coalition for health planning. Despite the well-documented need for the project and the Center's previous experience, the project was not funded. The Center nevertheless hopes to continue its work in health planning and seek other sources of funds.

For further information, contact Eddie Sissons, Arizona Center for Law in the Public Interest, P. O. Box 2783, Phoenix, Arizona, 85002, phone (602) 252-4904.

MDs "Assess" Canada's Health System

If you want to know how physicians assess health delivery systems, read their newspaper, the AMA News (535 N. Dearborn St., Chicago, Ill. 60610). The January 13 issue had a nine page review of the Canadian national health insurance program, the model for the Kennedy-Corman Health Security Bill backed by the Committee for National Health Insurance. Eight of the nine pages were devoted to complaints by doctors about not making enough money (doctors in Ontario averaged "only" $46,000 per year), overwork, and red tape. Almost nothing is reported on quality of care or on the fact that the entire population receives comprehensive health care without any substantial charges through a tax-financed program. However an AMA reporter wrote: ". . . I had to conclude that most Canadiens enthusiastically endorse their provincial health plans. They think highly of their physicians and the service they receive, and they appreciate not having to pay out-of-pocket costs for office visits or hospitalization. Time and again I heard people say 'The health plan's terrific!' 'It's great.' 'I don't know how you people in the states get by without it.'"

Chicago Consumers

Consumers for Health Action (CHA) has organized as an affiliate of the Association of Health Care Consumers (see story above). It is based in Chicago and is primarily concerned with insuring that the City of Chicago HSA is responsive to citizen participation and operates in compliance with federal law and regulations. In Chicago the city government operates the HSA.

CHA has written the Illinois Statewide Health Coordinating Council, urging it to reject the HSA's application for full designation. The letter criticized the HSA for several inadequacies. The HSA decided not to establish subarea councils and had no community meetings for the first 15 months of conditional designation and no newsletter for the first 18 months. The HSA reviewed $200 million worth of projects without a single disapproval and without first publicly adopting procedures and criteria as required by Federal regulations. Low income consumers are underrepresented on the Governing Board and committees are dominated by 3 people, 2 of whom are providers. Members are all appointed by the Mayor.

For further information, contact Consumers for Health Action, 109 N. Dearborn St., Suite 1202, Chicago, IL. 60602, phone (312) 641-5766.

It's Official!

HEW has spent 1/2 million dollars on a study which concluded: "Women and lower-status occupational groups were generally underrepresented on the [HSA] governing boards. There was an even greater tendency for these groups to be underrepresented on executive committees." The report also noted that: "there was significantly less minority and female representation among provider members as compared to consumer members. Minorities were generally underrepresented on both the HSA and SHPDA professional staffs of these agencies, but overrepresented on the support staff." A copy of the report summary "Board and Staff Composition of Health Planning Agencies" (DHEW Publ. No. (HRA) 78-609) is available from Health Resources Administration, Center Bldg., 3700 East-West Highway, Hyattsville, Maryland 20782.

Penn State Educates Consumers

The W. K. Kellogg Foundation has awarded a $231,000 grant to the Pennsylvania Cooperative Extension Service to increase the knowledge and skills of citizens involved in planning and developing community health services. This program builds on educational materials developed earlier (See August 1977 CHAN, p. 6). Approximately 1,000 Health Systems Agency (HSA) volunteers in Pennsylvania and part of New York assisted in identifying the topics for the Health Trustees Leadership Program; including: assessing a community's health care needs; determining the quality of care; understanding the basic economics of the health care system; and evaluating existing and proposed health services. Educational materials will be developed to support each program topic. For further information contact: Carol Riddick, the Pennsylvania Cooperative Extension Service, Community Affairs Section, 106 Weaver Building, University Park, PA, 16802, phone: (814) 863-0339.

BRIEFS

Chairman Dan Rostenkowski's Health Subcommittee of the House Ways and Means Committee has narrowly approved a standby hospital cost containment bill, a considerably weakened version of the bill proposed last year by President Carter (see August 1977 CHAN). Controls would not take effect unless the hospital industry fails to reduce the rate of increase in hospital spending by 2 percent a year under their much publicized but non-implemented "voluntary effort." Even this bill may not be approved by the other committees involved. Shortly before the vote was taken, Common Cause released a report on how much subcommittee members had received in campaign contributions during their 1974 and 1976 campaigns from the AMA and the Federation of American Hospitals (profit-making hospitals)--a total of $73,000, $10,500 to Rostenkowski.

The April 1978 Consumer Health Update - a newsletter for Philadelphia area consumers which is an insert in the HLP Library Bulletin - has a case study of how an HSA can bring about cooperation between two hospitals by using its review powers wisely. Two Philadelphia hospitals eight blocks apart, St. Joseph's and St. Luke's, both have applied to replace their current facilities. After several meetings, the Philadelphia HSA has decided to consider the applications together and to try to get commitments from both hospitals to plan jointly for health care in North Central Philadelphia. Whether this progressive approach will succeed remains to be seen.

Southern Exposure magazine has just published an excellent special issue on health in the South titled "Sick for Justice" (Summer 1978 issue). It has dozens of articles and features on occupational health, medical education, health workers, preventive health, toxic substances, and profiles of 5 community clinics. Copies are $3.00 each, $2.25 each for more than 10 copies. Write Southern Exposure, P. O. Box 230, Chapel Hill, N.C., 27514, phone (919) 929-2142.

The General Accounting Office (GAO) recently completed its study of the Los Angeles HSA (see November 1977 CHAN), finding serious deficiencies. The HSA spent most of $1.2 million on preparation for elections, which were conducted illegally; staff did not meet education and experience requirements; criminal charges have been referred to the Justice Department. The State Health Council refuses to allow the HSA to participate in certificate of need review. GAO was especially critical of HEW monitoring of the HSA.

Also in the April 1978 HLP Bulletin is an article by Louis Tannen, "A Practical Approach to Planning for People's Health Needs" (part of the series called "Consumer Issues Around HSAs"), which explains in non-technical terms the difference between population-based planning, which starts with the health needs of people, and resource-based planning, which is based on the experience of existing health institutions.

Slowly, consumers are being allowed to peer through the medical veil. In the April 1978 Health Law Project Library Bulletin (a rich source of information for health consumer activists: write to HLP, 133 S. 36th St., Rm. 410, Philadelphia, PA, 19104), there is an article about state medical licensing boards, "Can Doctors Police Doctors," by health law professor Sylvia Law, who contends that consumers have overlooked this important type of regulation. For example, the Brown Administration in California has made its Board of Medical Quality Assurance, which licenses many types of health professionals, into a consumer advocacy agency by appointing lay persons and increasing staff. (See American Medical News, Apr. 21, 1978, p. 11).

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CONGRESSIONAL ACTION AND YOUNG CHILDREN: 1818-

FAMILY SEPARATION

1819 Civilizing Act

1933 Title V Social Security Act (Child Welfare)

1940- 1968 Ammendments to Title 1V Social Security Act

1970 Title XX Social Security Act -- W.I.N. program

FAMILY SUPPORT

Economic support

1890 Pension Act

1933 Title 1V Social Security Act (Aid to Dependent Children)

Social support

1865 Creation of Freedmens' Bureau

1912 Creation of Childrens' Bureau

1965 Authorization for Head Start

WHAT WILL THE FUTURE HOLD: SEPARATION OR SUPPORT

Operation Common Sense	The fate of Federal Interagency Day Care Regulations
Head Start	Who willreceive services, who will deliver them?
Welfare Reform	Family support or family separation

White House Conference on the American Family

Barbara Finkelstein
University of Maryland
College Park, Md. 20742

1978

Esther Peterson -
growth of special interest powers is frightening
Every state has an office of consumer affairs
Regulation by States - utility rates - structure -
Insurance - Federal no-fault standards
10th anniversary - Truth in lending Act.
Complaints - Auto repairs
Pres. Economic Committee

Product liability - Modified tort -
* Lou Harris - Century Insurance - "Consumerism at the Crossroads"

@ETA

goals - more non traditional jobs for women.
Title III - include displaced homemakers
Employment service - veterans preferance
Concerns by Congress - view
use of bill as a revenue sharing bill
fraud - high salaries
People who were designated to be helped aren't being served
lots of tensions - particularly about who is being
In legislation - 18 mo limit - salary restriction - clerical subsidy
$2 bil program to $11 bil program
Bipartisan bill - recognizes need for better management
CETA authorization - Relationship to Welfare Reform Hank Aaron could be new Title II of W.R. for structurally unemployed

Pres. proposes 725,000 jobs

Alexis Herman - Director of Women's Bureau

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We would be very grateful if you would send letters of appreciation, including your thoughts on the conference to those individuals who were responsible for these contributions.

"THE OUTLOOK FOR FEDERAL GRANTS TO CITIES"

Richard P. Nathan

Prepared for a

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and the

Maxwell School, Syracuse University

April 5, 1978

Syracuse, New York

Richard P. Nathan is a senior fellow at the Brookings Institution and heads the Institution's Monitoring Studies Group. The ideas and views presented in this paper are his alone and do not represent the position of the officers, trustees, or other staff members of the Brookings Institution. Nevertheless, appreciation is expressed to my Brookings colleagues, Paul R. Dommel and James W. Fossett, who have helped me in working on many of the subjects considered in this paper.

President Carter announced his urban policy ten days ago. In this paper on the outlook for the future of federal grants to cities, the key question to be asked is, will it make a difference? Will the Carter strategy and message stand as a landmark of urban policy; will it materially alter the level and distribution of federal grants to cities?

This paper is divided into two main sections. The first provides information on the current status of federal grants to cities as a baseline for evaluating the potential impact of the Carter program. The second section examines the Carter program in relation to this baseline and presents ideas about the possible effects of the Carter program on the outlook for the future of federal grants to cities.

The Baseline for Urban Policy

Among persons interested in national urban policy, there is now a widespread awareness that basic changes are occurring. I refer specifically to the dramatic growth in federal grants-in-aid paid directly to local governments. This is an important development for American federalism.

Typically, federal systems of modern day involve fiscal and regulatory relationships between the central government and the states (the regional or middle level); the states in turn are regarded as having supervisory responsibility for local units. In the four other countries which besides the U.S. can be considered members of the club of modern federalism--Canada, Australia, West Germany, and Switzerland--grants from the central governments are provided exclusively (or nearly so) to the regional or middle level (provinces, cantons, landers, or states).

Fiscal and regulatory relationships between the central and local levels are strongly resisted on many grounds--historical, legal, political.

The United States, at least in my view, still belongs to the club of modern federalism, but our brand of federalism is clearly changing. In 1979, one-third of the $85 billion in federal grants budgeted for states and localities will be paid to local units. If we put to one side welfare-type programs (AFDC and Medicaid) as I believe we should for purposes of this analysis, then currently half of all of the remaining federal grants to states and localities go to local governments. (Moreover, if we use figures developed by Seymour Sacks on federal grants to states that are "passed-through" to local governments, the proportion of non-welfare federal grants slated for local governments in 1979 is approximately 55 percent.)

This is a three-fold increase in the local proportion of federal grants over a decade. It is strongly manifest in the data which ACIR and Brookings staff members have developed showing the estimated proportions of federal grants allocated to some of the nation's largest cities (those selected for analysis) in 1978. Federal grants data have been collected from agency sources and compared to the projected own-source general revenue of these city governments. Variations are found depending on the role of the city versus overlying governments; the political point of view of the city, especially towards federal grants; and the level of the city's socio-economic distress. But the overall picture is remarkably clear. Federal grants are now big ticket items in city finance; this development especially reflects mushroomed growth

rates over the last two to three years.

John Shannon has discovered a good way to express this growth--that is, in terms of the relationship of federal grants to each dollar a city raises from its own sources. For Buffalo (which has a quite strong overlying county and an independent school district), for every dollar the city collects in its own revenue in 1978, it is estimated that the city will receive 69 cents in federal grants. For Detroit, which also has an overlying county and an independent school district, it is estimated that for every dollar the city raises on its own, the federal government will provide 70 cents. For Cleveland with a similar structural arrangement, the relative federal contribution is 69 cents. It should be noted that these figures omit fees and service charges, borrowing, and state grants from the base for comparison.

Table 1

Estimated Federal Grants as a Percent of
Own-source General Revenue for Selected Cities
in 1978 and Per Capita

	Percent	Per Capita
Detroit	69.6	$ 248
Cleveland	68.2	217
Buffalo	62.2	251
Milwaukee	61.0	116
Phoenix	58.3	116
Newark	55.2	251
St. Louis	54.7	223
Baltimore	53.3	258
Philadelphia	51.8	196
Chicago	38.7	107
Atlanta	36.0	150
Los Angeles	35.7	120
Boston	28.0	203
Denver	24.2	140
Houston	22.7	68
Dallas	17.8	54

Source: ACIR and Brookings staff estimates.

Direct federal grants to local governments had their real start in the U.S. in the Truman years, accelerated in the "Great Society" period, and then again under "New Federalism" revenue sharing and block grant programs of the Nixon-Ford period. Two-thirds of all general revenue sharing funds go to local governments; block grants also benefit localities materially. A further push in this direction was provided by the Carter administration's 1977-78 "economic stimulus package" of $13 billion over two years, $10 billion of which is in the form of additional grants to local governments for jobs (about half of this amount), local public works, and countercyclical revenue sharing.

There is a second dimension to this shift in American fiscal federalism which involves the distribution of federal grants.

Increasingly, "targeting" of federal grants on distressed communities (cities, counties, towns) has emerged as an idea and an issue on the domestic policy scene in Washington. The name of the game is formulas; the aim here is to devise or modify formulas and eligibility tests so as to concentrate federal policy on the most needy cases and conditions.

The muted debate in 1977 (although it was a debate) over the so-called "dual formula" for distributing community development block grant funds was an important event in this context. The dual-formula concept was endorsed and strongly supported by HUD secretary Patricia Harris and her predecessor, Carla Hills. It was adopted as the policy of both the Ford and Carter administrations (though modified some by the latter) and enacted into law in 1977. A similar debate over the formula for distributing local public works funds in 1977 was decided on a basis that favors distressed local governments. And finally, the

Carter stimulus package for 1977-78 involved grants to localities which in the main are distributed according to local unemployment rates, a statistic that correlates well with local distress, both economic and social.

Several points by way of interpretation need to be made about targeting. First, while targeting has tended to benefit the frost belt, it has also materially affected distressed localities in the sunbelt--New Orleans, Birmingham, Galveston, Lubbock, Oakland, and Savannah.

Second, while targeting is emerging on the urban policy scene, it by no means dominates it. In fact, the more dominant long-term trend has been "spreading"--that is, the spreading of federal grants on a formula basis to literally thousands of local governments that never before received them.[1] Targeting is a recent development which, as just indicated, has modestly--but significantly--caused some recently-adopted federal grant-in-aid policies to provide disproportionately greater benefits to distressed local governments.

Underlying the targeting of federal grants is work that has been done by a number of researchers to develop generalized analytical techniques for identifying and gauging the social and economic distress of local governmental areas. It should be stressed that there is no ideal way to make these assessments. Because of the tremendous diversity and complexity of American federalism, plus the lack of needed and current data for local governmental areas, researchers at this stage can develop only limited instruments for analysing the social and economic conditions of urban areas. (For these same reasons, it is

almost impossible--maybe actually impossible--to index the fiscal conditions of local government.)

The various socio-economic indexing techniques which have been used at Brookings, HUD, the Urban Institute, Treasury, and by Terry Clark and others, are heuristic devices that can assist in the design of distribution formulas for federal grants-in-aid. In relation to targeting, they help policymakers to understand concepts and conditions which can be taken into account in the design of allocation formulas to concentrate federal policy on the most distressed conditions and cases.

One more point about targeting; the concept is more than arithmetic. It goes to heart of the issue of the role of the national government in domestic policy. In a healthy federal system where community control is a political value in high regard, we need continually to evaluate the role of the federal government. The essential idea of targeting is that under federal grants-in-aid the federal government's proper role in national domestic policy in a lively pluralistic political system is to concentrate its financial assistance on distressed jurisdictions.

This is not necessarily a liberal position. Those who believe that the role of the central government should be limited and that federal spending should be controlled to curb inflation might well agree that on efficiency and philosophical grounds the federal role in urban policy should focus especially on the most distressed communities.

There should, however, be no mistake about the aims and potential of a federal emphasis on aid to distressed communities. As my Brookings colleague Anthony Downs has stressed, a distinction must be made between

an "adjustment" and "revival" strategy for these communities. With the national population stabilizing, and the revolutions in communications and technology which facilitate population dispersal, there are distinct limits to urban policies focused on older and densely populated core cities and inner-ring suburbs.

The concentration of minority groups in many of these older and often blighted areas, plus the sunk costs in their capital plant and infrastructure, constitute major social and economic arguments for aiding the adjustment process. And, indeed, there is evidence--Baltimore, Boston, Pittsburgh--that an adjustment strategy and development progress are compatible goals for the nation's older and declining population centers. But the most distressed cities have a long way to go.

It has been our practice to visit in the field with associates involved in the Brookings monitoring studies; last week we visited St. Louis. Driving through the city, we were told that the high rate of abandonment and demolition has made St. Louis the second largest exporter of used bricks. As we passed a loading area of recovered bricks ready for shipment, one of the resident experts in the group said, "See that loading area. There goes St. Louis." Despite encouraging developments in Baltimore, Boston, Pittsburgh and promising housing rehabilitation trends in a few older cities (Washington, D.C. is a case in point), we must not be sanguine about the process and prospects for the nation's most blighted core cities--Newark, Detroit, Cleveland, St. Louis, New York, Buffalo, Hartford, New Orleans, to name some of the more prominent hard cases.

To review the dominant points to be considered as background for the Carter urban policy, there has been recent dramatic growth in direct federal-local grants and increasing targeting of these grants. In this context, last year--1977--was a banner year for urban policy. Both growth and targeting of federal grants to localities took quantum leaps with the enactment in 1977 of the CDBG "dual formula" and the Carter administration's "economic stimulus program."

What will 1978 be like? Answering this question, of course, involves examining more closely the Carter administration's urban policy announced on March 27.

The Carter Urban Policy

When the Carter urban policy was announced, several members of the monitoring group at Brookings drew up a tentative belance sheet of what appeared to us to be its plus and minuses. Heading the list of pluses was the emphasis of the Carter urban policy on targeting on urban distress. On the other side of the ledger at the top of the list of minuses or questions was the fact that the administration has not yet announced the specifications of its program in a way that would permit an analysis of its targeting capability. The Carter urban program is, in short, a program without a print-out.

Decisions have not yet been announced (in some cases they have not yet been made) as to what jurisdictions will be eligible for assistance under the National Development Bank, as to how soft public works funds will be allocated, as to the criteria for "certificates of necessity" for investment tax credit preference, as to the allocation of EDA title

IX funds to be tied to the new National Development Bank, and as to the allocation of funds under the new "highly targeted" ARFA program.[2] Likewise, for the 160 modifications of 38 existing programs, we do not yet have enough information to assess their impact on the distribution of federal funds to distressed communities--as, for example, in the case of the new HUD tandem plan for distressed cities mentioned at the briefings on the Carter urban policy.

This is not to say that the targeting theme is insincere or necessarily qualified, just that its seriousness cannot yet be gauged. The programmatic specifications needed apparently are still several weeks in the offing.

There are, however, quite a few things we do know about the Carter urban policy, despite the fact that, at least in my opinion, the distributional issue is critical. We know what programmatic elements (and there are many) it includes. We know the size and scope of the program. We know something about the way it deals with important issues regarding the federal system and political structures. We know, at least I think we do, that the program contemplates no changes in existing major flows of federal funds for revenue sharing, block grants, CETA, etc.

I suggest that there are three levels of questions about the Carter urban program that should be considered in April 1978. They involve its (1) contents, (2) workability, and (3) long-term implications. Each is discussed in the sections which follow:

1. Contents of the Program. This point essentially repeats what has been said--namely, that we do not yet know what the program really is because we do not have enough information.

2. Workability. The second level of questions involves the implementation of the Carter urban policy. Little has been said so far about steps that have been taken with the Congressional leadership to arrange (as in the case of welfare and energy policy) for some kind of comprehensive mechanism on the Hill for considering this broad--and I would add, very incremental--program. The proposals involved come very late in the Congressional budgetary calendar for fiscal year 1979, and, even then, are not yet ready for Congressional consideration. There are signs that important Congressional leaders are not disposed to move rapidly enough on the new initiatives proposed to complete action on a basis that would achieve the budgetary effects proposed for the 1979 budget, or for that matter, for the 1980 and 1981 budgets. Some of the increments to present program (parks, social services, the arts, etc.) stand a better chance of consideration this year, but proposals which require new authorizing legislation are in these terms questionable.

Altogether, the projected outlay impact of the Carter urban program in 1979 is equal to about 2.5 percent of total federal grants to localities estimated for 1979, rising over three years to approximately 8 percent in 1981. A summary of the projected impact of the program is shown in table 2, which includes budget authority, revenue reductions, and loan guarantees.

Table 2

Summary Budget Data on Initiatives
Contained in Carter Urban Policy
(in millions of dollars)

	1979	1980	1981
1. Outlays	742	2,933	2,874
2. Budget authority	4,419	6,087	5,642
3. Revenue reductions	1,700	1,700	1,500
4. Loan guarantees	(2,200)	(3,800)	(5,000)

Source: "New Partnership to Conserve America's Communities," Office of the White House Press Secretary, March 27, 1978.

Part of the outlays shown plus all of the amounts on lines 2-4 of table 2, require new authorizing legislation.

There is another aspect of workability, administrative follow-through on the idea of a comprehensive urban program. This especially involves the administration's capability to maintain a White House focus on program design issues and on the ambitious government-wide review process for existing urban programs. URPG will not continue in existence, which at least as an acronym won't be missed. A new assistant secretaries' group is to be set up, but the plans for the organization and even the chairing of this group are not yet known.

3. Long-term Implications. The third level of questions involving long-term policy implications is more subtle. If for the moment we assume that the administration's targeting theme will be expressed in

a manner that is considered to be appropriate, does this long-ball approach to urban policy make the most sense?

Here we are faced with questions of tactics. This administration, like many before it, has a tendency to go for the fences. Anxiously awaited and well-publicized "reforms" have been advanced in many fields. Is this across-the-board approach to domestic "reform" (albeit a quite incremental one in the case of urban policy) a better tactic than just picking out initiatives and advancing them separately--for example, an urbank, a jobs program, a parks program, whatever?

The essential issue here is what goes up front. If targeting goes up front, is it going to be easier or harder to achieve? I by no means think that in Washington an issue as big as targeting could be hidden under a rock, or that it should be. The question is how much trumpeting it should receive. The band, to maintain the metaphor, will play on.

We already see evidence that suburban interests, rural interests, small town interests, sunbelt interests, not to forget state governments and neighborhoods, are reaching for the new federal cookie jar called urban policy. Their claims are legitimate and strongly felt. The basic issue is the perennial one, compared to what; compared to the problems of distressed communities, how should we assess other claims? Putting targeting out front may increase the intensity of the competition in a way that in the final analysis disadvantages the most distressed cities which afterall have been losing population and Congressional representation.

One more point must be made in this connection. Despite the lack of political clout of distressed cities, the Congress and the country in 1977, and really over a long period, have been taking their special

needs into account in many welfare and grant-in-aid policies. Both types of programs have expanded appreciably, with welfare-program growth coming somewhat earlier than the recent spurt in growth in federal grants to cities.

I would sum up as follows: Perhaps in two months we will know, in terms of the targeting-spreading issue, what the Carter program <u>really</u> is. And perhaps in five years we will be able to speculate intelligently as to whether this program and the handling of this issue by President Carter in 1978 advanced or retarded the momentum of increased, and increasingly targeted, federal grants to local governments.

To respond specifically to the question raised at the beginning of this paper--will the Carter program make a difference?--the answer offered here (not a very satisfactory or dramatic one) is that we don't know yet. For a short-run assessment, we need more programmatic information. As regards a longer-term perspective, we can do little but frame the issue and watch the process.

On a less cosmic basis, several other observations are in order about the Carter urban policy. Besides the targeting emphasis, three other important elements are its emphasis on attracting private investment in distressed communities; various measures which would affect the role of states, localities, and neighborhood groups; and the plan for a comprehensive review of existing programs to bring them into line with the purposes of the administration's national urban policy. The first two of these subjects are separately discussed below.

1. Attracting Private Investment. The National Development Bank and attendent tax incentives and increased expenditure proposals for HUD and EDA, if formed into a cohesive program, would represent a significant new thrust for national urban policy. There are still questions of specification to be answered, but there is a decision, at least tentatively, to establish a new institutional entity to be called a "National Development Bank" under the supervision of a tripartite Cabinet committee. Such an institution--called a bank--is significant, not only programmatically, but also organizationally. It offers an opportunity to bring fresh energy to bear for a focus on job-creating and tax-base building efforts in distressed communities.

Many people have commented on this idea, some saying it is too vague (and that it still is), others that an urbank (or National Development Bank) is a potentially important policy and organizational initiative. Besides its programmatic impact, a bank could provide what the administration needs--that is, a visible symbol of its urban policy, as well as another voice, in addition to Secretary Harris's, to call attention to the need to deal with and relieve urban distress conditions.

2. Implications for Federalism. At the briefing for mayors on the Carter urban policy, one mayor likened the city position under the new policy to being in the middle of a giant nutcracker. On one side is new grants to states which "reorient" resources "toward existing communities and those in decline or distress."[3] On the other is grants from the federal government directly to neighborhood groups. A number of mayors at the briefing raised similarly critical questions about both arms or sides (or whatever) of this urban nutcracker; other mayors have supported

these proposals.

Potentially far-ranging questions of political structure are raised by these and other parts of the Carter urban policy. On the decentralization continuum, it moves back towards the categorical position and away from the revenue sharing idea.[4] It proposes to create a number of new categorical grants, to expand others, and raises the possibility that, through the review of present programs, existing federal "strings" will be pulled more tightly. In addition, Carter's urban policy envisions a somewhat different role for the national government in relation to cities, states, and neighborhood organizations.

These changes, taken together, could turn out to be the sleeper in the Carter urban program. To date, the administration has not departed in dramatic ways from the "New Federalism" themes involving the usual words and symbols to show that a strong role for state governments and local control are treasured political values. The urban policy, however, opens the door for change, even though the words are quite cautious on this issue. Giving funds to states (in point of fact, a mere $.2 billion per year) to get them to reorient their grant policies involving over $60 billion in state grants to localities is hardly a bargain. But it could cause changes that would weaken--not strengthen--the state role at a time when states, as the middle man of American federalism, are, relatively speaking, losing ground anyway.

Something approximating one-third of the amount proposed for the states is to be spent to aid neighborhood groups. These funds would, I presume, come directly from Washington--not through the city or other

local jurisdictions, as in the case of CETA and CDBG funds. The picture that comes to mind here takes us back to the OEO and Model Cities days, though there is the prospect now that better-off (though not well-off) neighborhoods would be included under these new programs.

In any event, these potential structural changes (additional categorical grants and strings, plus new federal relationships with states, cities, and neighborhood groups) constitute an area to watch as the urban policy process plays out. Although I don't see strong signs of it yet, both budgetary contingencies and ideas currently being discussed, suggest that the next watershed of Washington initiatives in domestic policy (on the order of the "Great Society" or the "New Federalism") will be in the form of structural interventions to affect the boundaries and responsibilities of state and local governments and regional and neighborhood entities.

There is no question but that issues of boundaries, functions, and political structures are at the root of problems of urban distress and program equity in the domestic public sector. The key question for the future of federalism is whether in any strong way the central government should intervene in these matters. The Carter urban policy handles this issue gingerly, but the issue is still there.

By Way of Summing Up

Before the Carter urban policy was announced, I would have said that the overall outlook for federal grants to cities at the present time is: (1) the growth rate will slow down; (2) there will be a modest further tendency toward categorization; and (3) targeting on community

distress will in the future be harder to achieve. As Robert Reischauer's paper for this conference stresses, the future for federal grants is in no small measure dependent on the condition of the economy; strong growth or a plateauing of the economy reduces the rationale for counter-cyclical spending, which has tended to materially benefit city governments.[5] It also needs to be noted that other administration policies--jobs and CETA, mass transit and UMTA, the environment and EPA, and tax policy--affect urban areas.

In any event, it is too early yet to make firm predictions about the likely effect of the Carter urban policy. Early indications are that it will not materially affect the level of federal grants to cities and that it will reinforce the tendency towards categorization. Its impact on the distribution of federal grants to local governments, as noted earlier, cannot yet be discerned in the tea leaves of urbanology.

Footnotes

1. Spreading has taken two forms: increased support for smaller city governments in general and for larger cities in the South and West that were not active as participants under the older categorical programs. In 1968, for example, cities under 100,000 in population received 20.3 percent of all federal grants to cities. By 1976, this share had risen to 30.3%. The share of cities over 500,000, by contrast, declined from 62.2% in 1968 to 44.4% in 1976. Similarly, many cities in the South and West have received larger increases in federal support since the advent of general revenue sharing than older declining cities. A comparison of growth in federal grants over the period 1972-78 for eight northeastern and midwestern cities and nine sunbelt cities indicated that the sunbelt cities had increased their federal revenue by an average of 585%, as compared with 354% for the northeastern cities.

2. In the author's opinion, the administration would have been well advised on both substantive and tactical grounds to have requested an extension of the countercyclical ARFA program. This would broaden support for an interim targeted component (as proposed) and avoid delays in future periods of economic decline.

3. "New Partnership to Conserve America's Communities," Office of the White House Press Secretary, March 27, 1978, p. 9. The language is interestingly vague.

4. This trend towards recategorization is also apparent in a number of recent administrative and legislative proposals made by the administration. The proposed extension of the PSE legislation, for example, imposes revised limits on eligibility, wage supplementation and participation. The new youth programs added to CETA in 1977 are categorical. Furthermore, recent regulations for the community development block grant program impose requirements that 75% of certain expenditures under this program for a three-year period should principally benefit low- and moderate-income individuals. This tendency is offset to some extent by other proposed changes such as the administration's proposal to consolidate several transportation programs and equalize the matching ratios between different types of projects.

5. Robert D. Reischauer, "The Economy, the Federal Budget and the Prospects for Urban Aid."

Mount Vernon College
2100 Foxhall Road, NW Washington, DC 20007

The Front Page

Dr. Susan Tolchin-Teacher of The Year

Dr. Susan J. Tolchin is the Director of the Washington Institute for Women in Politics, a national center for women interested in careers in politics and public service service. She is also an Associate Professor of Policial Science here at Mount Vernon. A political scientist by profession, she has co-authored two nationally recognized books: *Clout: Womanpower and Politics* and *To The Victor: Political Patronage from the Clubhouse to the White House. To the Victor* was cited by the U.S. Supreme Court in *Elrod v. Burns* on June 23, 1978 as one of the leading works in the field. Her third book, *Women in the U.S. Congress*, has been published by the Joint Committee on the Bicentennial of the U.S. Congress. She has also published many articles, appeared on national television and radio shows, including the *Today Show*, and has lectured throughout the country on the subject of the emerging role of women in politics.

Dr. Tolchin received her Ph.D. from New York University, her M.A. from the University of Chicago and her B.A. from Bryn Mawr College.

As Director of the Drew University Washington Semester Program at George Washington University, she ran programs which combined political science coursework with field work experience. She has also served on the facultires of the City University of New York and Seton Hall University, where she taught a broad spectrum of political science courses, most of them in the field of American politics. Presently, she is President of the Women's Caucus of the American Political Science Association.

In the area of practical politics, Dr. Tolchin has served as Democratic County Committee person and district leader from Essex county, New Jersey. During her four years as district leader, she ran campaigns and acted as a community organizer in traffic safety legislation. Dr. Tolchin serves on the following boards: Sage Electoral Yearbook, an annual text focusing on current theories of voting behavior; the State National Bank of Maryland, Bethesda Women's Headquarters; Women's Campaign Fund; and the International Women's Year Conference Board for the State of Maryland.

Dr. Tolchin's wide range of political experience and academic expertise has proved invaluable to her students. Her political contacts have also served to assist students with job searches, internships and research. Despite Dr. Tolchin's involvement on a local and national scale, she finds time to serve on faculty committees, counsel students, supervise Independent Study projects and arrange special seminars and conferences sponsored by the Institute. Not the least of her activities, she is the mother of two bright and aware children, charles, age 9 and Karen, age 7. Dr. Tolchin and her husband, Martin, White House correspondent for the New York Times, find that their respective careers are quite complementary and compatible.

Our congratulations to Dr. Susan Tolchin on an outstanding political and academic career. We know that we will be hearing more from this year's "Teacher of the Year."

Children's Defense Fund

1520 New Hampshire Avenue, Northwest
Washington, D.C. 20036

Telephone 202-483-1470

COMING UP IN CONGRESS IMMEDIATELY TO
IMPLEMENT CDF'S NATIONAL LEGISLATIVE AGENDA.....

LEGISLATIVE UPDATE #1

1. CHILD WELFARE

Bill No. H.R. 7200*

Contents

The child welfare provisions of H.R. 7200 (as passed by the House) would, among other things, increase funds available for services to prevent placement and to reunify children with their families, create a federal adoption subsidy program for hard-to-place children, and require states to institute a series of foster care protections, for example, placement of children in the least restrictive setting close to home, preventive and reunification services, dispositional hearings, periodic case reviews, and due process procedures for children in out-of-home placements.

These provisions in the Senate Finance Committee version of H.R. 7200 (Title I) are on the whole weaker than those in the House-passed bill, although they would improve the adoption subsidy program in the House bill and extend Medicaid benefits to children with special needs after their adoption. One specific weakness in the Senate Finance Committee version is that it would only rhetorically encourage rather than mandate states to develop the types of foster care protections contained in the House bill. Of equal concern is the addition by the Senate Finance Committee of numerous controversial non-child welfare related provisions to the bill. Passage of the vitally important measures to protect children at risk may not be possible unless Title I can be separated from the "Christmas tree" and voted on alone by the Senate.

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*For details, request "Public Assistance Amendments of 1977," H. Rpt. 95-394, from the House Ways and Means Committee; and S. Rpt. 95-573 (same title), from the Senate Finance Committee.

Status

H.R. 7200 must be acted on by the full Senate and by a joint House-Senate Conference Committee. While there is no definite schedule yet, action by the full Senate is expected to occur following action on the second Panama Canal treaty. H.R. 7200 will not likely be acted upon until mid-April at the earliest. We are concerned that unless the Senate is encouraged to vote soon on Title I, Congress may not take the time to complete action (through a Conference Committee on the two versions) in an election year.

Action Needed

Write your Senators to urge immediate floor action on Title I of H.R. 7200, the child welfare provisions, as reported by the Senate Finance Committee.

Who to Contact

Senators from your state.

2. CHILD HEALTH: Strengthen and Enact CHAP

Bill Nos. H.R. 6706/S. 1392 and H.R. 10771

Content

Late last April President Carter sent to Congress a proposal (H.R. 6706/S. 1392) for a "Child Health Assessment Program" (CHAP) to "expand and improve" the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. In September, Congressman Maguire (D.-N.J.) introduced a separate bill (now H.R. 10771), also designed to improve the implementation of EPSDT and which corrects many of the original weaknesses of H.R. 6706. Both proposals would attempt to serve a greater number of poor children not now served by EPSDT. In addition, CDF favors provisions to strengthen outreach, establish minimum performance standards and effective enforcement mechanisms, and expand dental and mental health coverage. Otherwise, we fear the new program will not really reach needy children.

Status

In late February, the House Subcommittee on Health and the Environment of the Interstate and Foreign Commerce completed tentative decision-making on a series of issues in H.R. 6706. While some of the key areas of concern to child advocates like outreach and enforcement were not effectively addressed initially, the Subcommittee will reconsider these decisions before taking final action. This will occur in late April. Once a proposal emerges from the Subcommittee, it must be reported out by the full Committee and passed by the full House; then by the Senate Finance Committee and the full Senate.

Action Needed

Communicate to members of the full Committee your support of preliminary Subcommittee decisions made to improve the EPSDT program. Urge them to support strong outreach, outcome standards and enforcement provisions when the bill is considered further by the Subcommittee and the full Committee.

Also inform your Senators that speedy Senate action is required if CHAP legislation is to be enacted this year. Urge them to communicate this to Senators Russell Long (D.-La.), Carl Curtis (R.-Neb.) and Herman Talmadge (D.-Ga.) of the Senate Finance Committee.

Who to Contact:

Members of the House Interstate and Foreign Commerce Committee are:

Democrats	Republicans
Harley O. Staggers (West Virginia)	Samuel L. Devine (Ohio)
John E. Moss (California)	James T. Broyhill (North Carolina)*
John D. Dingell (Michigan)	Tim Lee Carter (Kentucky)*
Paul G. Rogers (Florida)*	Clarence J. Brown (Ohio)
Lionel Van Deerlin (California)	Joe Skubitz (Kansas)*
Fred B. Rooney (Pennsylvania)	James M. Collins (Texas)
John M. Murphy (New York)	Louis Frey, Jr. (Florida)
David E. Satterfield III (Virginia)*	Norman F. Lent (New York)
Bob Eckhardt (Texas)	Edward R. Madigan (Illinois)*
Richarson Preyer (North Carolina)*	Carlos J. Moorhead (California)
Charles J. Carney (Ohio)	Matthew J. Rinaldo (New Jersey)
Ralph H. Metcalfe (Illinois)	W. Henson Moore (Louisiana)
James H. Scheuer (New York)*	Dave Stockman (Michigan)
Richard L. Ottinger (New York)*	Marc L. Marks (Pennsylvania)
Henry A. Waxman (California)*	
Robert (Bob) Krueger (Texas)	
Timothy E. Wirth (Colorado)	
Philip R. Sharp (Indiana)	
James J. Florio (New Jersey)*	
Anthony Toby Moffett (Connecticut)	
Jim Santini (Nevada)	
Andrew Maguire (New Jersey)*	
Marty Russo (Illinois)	
Edward J. Markey (Massachusetts)*	
Thomas A. Luken (Ohio)	
Doug Walgren (Pennsylvania)*	
Bob Gammage (Texas)	
Albert Gore, Jr. (Tennessee)	
Barbara A. Mikulski (Maryland)	

*Members, Subcommittee on Health and the Environment

3. CHILD CARE AND FAMILY SUPPORT SERVICES

Bill No. H.R. 7577/S. 2090: Renewal of and More Money for Project Head Start

Content

CDF supports reauthorization of the Head Start Program with the same flexible delivery system, strong parent and community involvement provisions and administrative location within HEW's Administration for Children, Youth and Families.

Those concerned about Head Start should be aware that Congressional deliberations on H.R. 7577/S. 2090 could result in major changes in how funds are distributed in the future. CDF favors expansion of Head Start but wants to protect the quality of existing Head Start programs. We are therefore urging that each Head Start program be assured adquate funding at the 1978 level, plus a cost-of-living increase; and that any increased appropriations secured be distributed in a fair and equitable way.

Status

The House Economic Opportunity Subcommittee first brought H.R. 7577 --renewal legislation for the Economic Opportunity Act--to the full Education and Labor Committee in late September and both Committees agreed to report the bill at that time. However, the question of how Head Start formula funds will be distributed remains unresolved.

In the Senate, the Senate Subcommittee on Poverty, Employment and Migratory Labor has completed final hearings on S. 2090 and expects to report legislation in time to meet the May 15th budget deadline.

Action Needed

Make your support of Project Head Start in its present form and the formula as described above known to your Representatives and Senators. Send copies of your letters to Reps. Carl Perkins (D.-Ky.), Ike Andrews (D.-N.C.) and Albert Quie (R.-Minn.); all of the House Committee on Education and Labor; and to Senators Gaylord Nelson (D.-Wis.), Harrison Williams (D.-N.J.), Jacob Javits (R.-N.Y.), Alan Cranston (D.-Ca.) and Donald Riegle (D.-Mich.) of the Senate Human Resources Committee.

Bill No. S. 991: Exclude Head Start from any Separate Department of Education

Content

Co-sponsored by Senator Abraham Ribicoff (D.-Ct.), Chairman of the Committee on Governmental Affairs, and over fifty other Senators, S.991 would create a separate, cabinet-level Department of Education.

Because of its unique status as the only truly comprehensive federal child care program serving children, families and communities, CDF believes Project Head Start should remain outside a separate education department if created. Despite initial assurances to the contrary, we fear inclusion in such a department would be a forerunner to eventual public school control and a weakened role for parents and poor and minority communities in their children's lives.

Status

Though the Senate Governmental Affairs Committee has no definite timetable yet, it has already heard and will hear additional testimony from the Administration regarding its intentions on the issue of a separate department.

Action Needed

Inform the following key members of the Senate Governmental Affairs Committee and the House Government Operations Committee of your opposition to inclusion of Head Start within a new department of education: Senator Abraham Ribicoff (D.-Ct.), Sen. Charles Percy (D.-Ill.), Rep. Jack Brooks (D.-Tex.), and Rep. Frank Horton (R.-N.Y.).

Federal Interagency Day Care Requirements (FIDCR) Appropriateness Report and Standards

Inform your Senators and Representatives of your commitment to strong, child-centered Federal Interagency Day Care Requirements for programs receiving federal funds under Title XX of the Social Security Act. HEW's present draft appropriateness report fudges these issues and must be strengthened.

4. EDUCATION: Reauthorize and Increase Funds for Title I of the Elementary and Secondary Education Act

Bill Nos. H.R. 11282 (H.R. 10891)/S. 1753

Content

The Administration's reauthorization legislation (H.R. 11282/ S. 1753) for the Elementary and Secondary Education Act (ESEA) was sent to Congress this year and is currently under consideration. Of particular concern to child advocates is Title I of ESEA, which targets additional resources for school districts with large numbers of poor children.

Representative Carl Perkins (D.-Ky.), Chairman of the Subcommittee on Elementary, Secondary, and Vocational Education, has decided to use an alternative bill, H.R. 10891, to complete work on Title I's renewal. This bill is important for children because it would strengthen and broaden existing parent participation requirements.

Status

The House Subcommittee on Elementary, Secondary, and Vocational Education has completed markup on H.R. 10891. The full Education and Labor Committee is scheduled to meet on Title I in early April.

The Senate Subcommittee on Education, Arts, and Humanities has held preliminary hearings on S. 1753 and is scheduled to begin its markup April 15th.

Action Needed

In addition to strengthened parent advisory councils, CDF supports:

(1) maintaining the distribution of Title I funds based on a poverty measure;

(2) full funding to extend services to secondary students and to establish summer programs designed to assist students in maintaining academic achievements made during the school year;

(3) increasing set-aside funds or establishing a separate set-aside appropriation for "follow the child" purposes; and

(4) strengthened enforcement provisions to ensure more effective Office of Education review of state plans and State Educational Agencies' reviews of local programs according to designated timetables.

Members of Congress should be asked to support these provisions.

Who to Contact

Your Representatives and Senators and members of the following Committees:

Senate Human Resources Committee

Democrats

Harrison A. Williams (New Jersey)
Jennings Randolph (West Virginia)*
Claiborne Pell (Rhode Island)*
Edward M. Kennedy (Massachusetts)*
Gaylord Nelson (Wisconsin)
Thomas F. Eagleton (Missouri)*
Alan Cranston (California)
William D. Hathaway (Maine)
Donald W. Riegle, Jr. (Michigan)

Republicans

Jacob K. Javits (New York)
Richard S. Schweiker (Pa.)*
Robert T. Stafford (Vermont)*
Orrin G. Hatch (Utah)
John H. Chafee (Rhode Island)
S. I. Hayakawa (California)*

House Education and Labor Committee

Democrats

Carl D. Perkins (Kentucky)**
Frank Thompson, Jr. (New Jersey)
John H. Dent (Pennsylvania)
John Brademas (Indiana)
Augustus F. Hawkins (California)
William D. Ford (Michigan)**
Phillip Burton (California)
Joseph M. Gaydos (Pennsylvania)
William Clay (Missouri)
Mario Biaggi (New York)
Ike F. Andrews (North Carolina)**
Michael T. Blouin (Iowa)**
Robert J. Cornell (Wisconsin)
Paul Simon (Illinois)**
Edward P. Beard (Rhode Island)
Leo C. Zeferetti (New York)**
George Miller (California)**
Ronald M. Mottl (Ohio)**
Michael O. Myers (Pennsylvania)
Austin J. Murphy (Pennsylvania)**
Joseph A. LeFante (New Jersey)**
Theodore S. Weiss (New York)**
Cecil Heftel (Hawaii)**
Baltasar Corrada (Puerto Rico)**
Dale E. Kildee (Michigan)**

Republicans

Albert H. Quie (Minnesota)**
John M. Ashbrook (Ohio)
John N. Erlenborn (Illinois)
Ronald A. Sarasin (Connecticut)
John Buchanan (Alabama)**
James M. Jeffords (Vermont)
Larry Pressler (South Dakota)**
William F. Goodling (Pa.)**
Bud Shuster (Pennsylvania)
Shirley N. Pettis (California)**
Carl D. Pursell (Michigan)**
Mickey Edwards (Oklahoma)

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*Members, Subcommittee on Education, Arts, and Humanities

**Members, Subcommittee on Elementary, Secondary, and Vocational Education

5/25/78

Intergovernmental Fiscal Policy -
Dick Nathan

(1) How should we think about urban problems?
(2) Role of Federal Govt
(3) Leg. Issues in D.C.

(1) Brookings tried to index city problems. — (a) cities compared with their own suburbs. (b) cities with each other.

The U.S today does not have a national urban crisis. Some cities do - (1) they are generally older cities (2) they are typically losing people (3) they are losing jobs (4) high concentration of dependent people (5) High proportion of minorities

(6) boundries have a different kind of dimension - pre auto planning eg. Det. St L Cleve Buffalo, N.Y. Hartford

(7) Some cities don't have urban problems.

Dallas, Houston, Pheonix. Seattle San Diego - post auto planning capability for burden spreading

Destressed

Galveston, Laredo Tx.

Birmingham, N.O.

Non distressed.

K.C. + Columbus

Theme 7 Breakmap research - there are urban crisis cities.

Federal role

(1) In the past 15 yrs. there has been

a vast change in Federal interchange - much greater direct relationship with local govts.

② Increasing attn. to idea of <u>targeting</u> federal grants. Question for us is formula for distribution.

Spreading effect - decision was made to allow small units of govt to receive fed. grants.

	1968	1976
Pop under 100,000	20%	30%
pop over 400,000	62%	44%

③ Carter policy - targeting approach
Modest shift
possibility of incremental welfare reform

CETA - Target populations.
Pillution to revenue sharing

John Callahan - over past 10 yrs.
Fed share of ed funding constant
Local govt share declining
State share increasing

Impact aid - administration favors -
Title I - changes to bring money into districts which have large numbers of Title I children

Special ed. - Mandate for serving in this area by this fall - but no funding.
General aid. No program.

Tuition tax breaks - 4-5 Bil yr.
1976 - 78 increase in aid to
52 bil — 72 bil state + local govts

Paul Sweet - Federal Preemption

22% of state budgets are Federal money

Fed. Trade Comm preempted state law on eyeglass advertising

Dangers

(1) loss of incentive for innovation

(2) narrows and weakens role of state legislatures.

Growth of large special interest groups

(3) Detrimental effect on programs

CETA - reauthorization - state plans must be sent to appropriate committee in legs for review.

TIME - Essay - June 1 (May 28?)

HARPERS - balkanization of American States

Kevin Phillips.

Committee oversight over Federal funds coming into state — Sub committee of finance

Health issues

Bob Derzon - 3400 employees

800 mil. per mo. - Medicaid

State-federal partnership

Medicaid - 7 mandated services

8-9 million do not have Medicaid.

Medicare - done in Bob's office look Medicare and Medicaid simply as vendor payments - 95-142 states can set up fraud and abuse programs - 40% federal input.

Uniformity & standards for medical lab services. - bill in Congress

Cost containment bills - states have a big stake - $737 for every man woman and child in U.S. health care bills - per capita for aged is 3 times that.

Rural Health clinics -

(1) states have to allow for reimbursement of non physician providers

(2) uniformity of reimbursement for Medicare + Medicaid needed

State rate setting hasn't been totally successful.

CON - 100,000 excess beds (conservative est.)

Home health services under Title XIX check!

Medicaid - approach from Social Model - talk to Medicaid director!

Consumer coalition

Herb Semmel - on health

HSA's will have power to approve or disapprove grants for compliance

By Sept. 1980 - States must have CON

State Health Plan - based on regional plan - Gov. and SHCC must approve

Cap on capital expenditures - 3 bil limit - formula for spending

Home health care services - check title XX

Harold Corfer -

Administration bill expected by end of July.

Components of NHI

① Universal + Mandatory

② Comprehensive benefits

③ Prospective budgeting

④ No cost sharing
③ Systems improvements

Marilyn Goldwater -
Maximum use of cost
effective systems
bill to reimburse nurse practitioners
+ nurse mid wives + passed.
FTE monitoring AMA
Coverage for stay in psychiatric
½ way facility

Need for <u>national health policy</u>

Barbara Finkelstein

*Cost of child care formulas for funding of Head Start are changing – check Ad. of Children, Families + Youth.

Patsy Fleming – Ex. Dir
Wilbur Cohen – Chmn.

Mental Health - Pres. Commission
Jane Jackson Christmas
Focus: mental health
? chronic patients - State
hospitals - money going to
community mental health centers
Children being underserved
Elderly - "
Women - inappropriately served
Minorities - Ethnic + racial
physically handicapped -

Final Document - The Presidents'
Commission on Mental Health
Report $ 2.75
Supt of Documents
Wash D.C. 20402

Recommendation: Community Health

Ann Swan? Madison husband - architect

Services

Serve the underserved

Fund approved services (enter)

Move to integrated mental health system -

Pat

Sally + Bill

Judith Turner - NIMH
Community Support Services

Require pre discharge planning process. N.Y.

State wide master plan - N.S.

Mental Health Law Project Review
202 567.

Mental Health in Schools -
Use schools for delivery of services

NEW Task Force on deinstitutionalization

The Washington Institute For Women In Politics

Mount Vernon College 2100 Foxhall Road N.W. • Washington, D.C. 20007 • (202) 331-3418

April 27, 1978

Dear Participant:

Our conference is shaping up extremely well, and you should receive your preliminary program within the next week. An exciting range of speakers and panels will be held. To name a few: Rep. Elizabeth Holtzman, co-chairman of the Congressional Women's Caucus; Ms. Esther Peterson, Consumer Advisor to the President; and Dr. Richard Nathan, fiscal expert at the Brookings Institution.

Registration will be held at 11:00 AM, Thursday May 25th, in Post Hall at Mount Vernon College and the conference will begin immediately afterward. Please time your flights and transportation accordingly. The college is located close to two major airports: thirty minutes from Dulles Airport; twenty minutes from Washington National Airport.

When you arrive on the campus, you can check in at the gate house, where you will receive your meal ticket, room assignment and key. A $5.00 key deposit will be required, refundable at the end of your stay. A student will be there to assist you.

Linens will be provided by the college. That includes sheets, towels and blankets.

Enclosed is a map of the campus for your further information.

The conference will end on Saturday, May 27th, after lunch. You can check out any time at your convenience that day.

The weather in the latter part of May will probably be hot and humid. The college is fully air-conditioned, but we suggest light, informal, comfortable clothing. We are planning a party for Friday evening; you may want to bring a long dress. In addition the Mount Vernon College pool will be open to all conference participants, so please bring bathing attire.

Looking forward to working with you.

All best,

Susan

Dr. Susan J. Tolchin

SJT/sal

P. S. We have put twenty five legislators on our conference waiting list. If you cannot attend, please let us know immediately so that one of these women can take your place.

The Washington Institute For Women In Politics

Mount Vernon College 2100 Foxhall Road N.W. • Washington, D.C. 20007 • (202) 331-3418

CURRENT LEGISLATIVE ISSUES OF THE '70's FROM A WASHINGTON PERSPECTIVE

A Workshop for State Legislators

PRELIMINARY PROGRAM

Thursday, May 25

11:00 a.m.-12:00 noon — Registration. . . . . Gate House and Post Hall

12:00-1:30 p.m. — Luncheon. . . . . Cafeteria

Welcome and Orientation:

Dr. Susan J. Tolchin
Director, Washington Institute for Women in Politics

Mrs. Esther Coopersmith
Director of Development for the State Legislators Conference

Dr. Victoria Schuck
President, Mount Vernon College

A Roundtable: Background and Interests of Conference Participants

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This workshop was made possible by the following grants:

American Federation of State, County and Municipal Employees

Hotel and Restaurant Employees and Bartenders International Union

Martin Marietta Corporation

United Auto Workers

Thursday, May 25

1:30-3:00 p.m. — The Importance of Consumer Protection at the State Level

Speaker: Esther Peterson,
Consumer Advisor to the President

Discussant: Alice Shabecoff,
Director, Neighborhood Relations Division, Office of Neighborhoods, Department of Housing and Urban Development

3:30-5:00 p.m. — New Approaches to the CETA Program

- Elements of Choice
- New Priorities
- Funding Levels
- Political Conflicts

Moderator:

Speakers:
Susan Grayson,
Staff Director, Subcommittee on Employment, U.S. House of Representatives

Richard E. Johnson,
Assistant to the Assistant Secretary, Department of Labor

Nanine Meicklejohn,
American Federation of State, County and Municipal Employees

6:00-8:00 p.m. — Dinner. . . . . Cafeteria

Current Federal Legislation Affecting Women

Speaker: Representative Elizabeth Holtzman (N.Y.)
Co-chair, Congressional Women's Caucus

Friday, May 26

9:30-11:30 a.m. — Federal Expenditure Programs Affecting the States

Moderator: Dr. A. Lee Fritschler
Dean, College of Public Affairs, American University

Speakers:
Dr. Richard Nathan,
Senior Fellow, The Brookings Institution
"A Review of Urban Policy Issues"

John Callahan,
Director of State-Federal Relations, National Conference of State Legislatures
"Education Seen as an Intergovernmental Transfer"

Disscussant: Del. Lucille Maurer (MD)

12:00-1:00 p.m. — Lunch . . . . . Cafeteria

Federal Preemption

Speaker: Paul Sweet,
Staff Director, Congressional Relations, National Conference of State Legislatures

1:30-3:30 p.m. — Developments in Health Legislation Affecting the States

- Health Planning Legislation
- Medicaid
- Cost Containment
- National Health Insurance
- Reimbursement for Nurse Practitioners and other Related Health Professionals

Moderator: Nina Solarz,
Representative, New York City Office in Washington

Speakers:
Robert Derzon,
Administrator, Health Care Finance Administration, Department of Health, Education and Welfare

Rep. Marilyn Goldwater, R.N. (MD)

Karen Ignassi,
Director, Committee for National Health Insurance

Robert McGarrah,
Public Policy Counsel, American Federation of State, County and Municipal Employees

4:15-5:00 p.m.

Public Policy and Children: The Educational Dilemna

Speaker: Dr. Barbara Finkelstein,
Professor of Education, University of Maryland

Saturday, May 27

9:30-11:30 a.m.

Report on the President's Commission on Mental Health:
Possibilities for New Federal-State Partnerships

- Areas of Increasing Federal Support
- Fiscal Problems
- Program Considerations
- Potential for State Legislation

Moderator: Barbara Roffwarg, Esq.,
Former General Counsel, New York City Commission on Mental Health, Mental Retardation and Alcoholism Services; presently a national consultant in health law

Speakers:
Dr. June Jackson Christmas,
Commissioner of Mental Health, Mental Retardation and Alcoholism Services of the City of New York

Discussants:
Rep. Chris Miller (Texas)
Rep. Linda Winikow (New York)

STATE LEGISLATORS

Arizona-

1. Rep. Donna J. Carlson (R)
   State Representative
   House Wing, State Capitol
   Phoenix, Arizona 85006

Colorado-

2. Senator Barbara S. Holme (D)
   1243 Fillmore
   Denver, Colorado 80206

Connecticut-

3. Rep. Nancy L. Johnson (R)
   141 South Mountain Drive
   New Britain, Connecticut 06405

4. Senator Barbara D. Reimers (R)
   258 Pine Orchard Road
   Branford, Connecticut 06405

Florida-

5. Rep. Helen Gordon Davis (D)
   732 Freedom Bldg.
   Tampa, Florida 32935

6. Rep. Marilyn Evans (R)
   1495 Harbor City Blvd., Suite G
   Melbourne, Florida 32935

Georgia-

7. Rep. Dorothy Felton (R)
   District #22
   265 Tanacrest Drive, NW
   Atlanta, GA 30328

Hawaii-

8. Rep. Faith P. Evans (R)
   687 Uluani Street
   Kailua, Hawaii 96734

9. Rep. Donna R. Ikeda (R)
   7th Representative District
   State Capitol Room 415
   Honolulu, Hawaii 96814

10. Rep. Kathleen G. Stanley (D)
    State Capitol
    Honolulu, Hawaii 96814

Maine-

11. Rep. Sharon B. Benoit (D)
    75 Parrot Street
    S. Portland, ME 04106

12. Rep. Nancy Cummings (R)
    Rowell Road
    Hampden, ME 04444

Maryland-

13. Delegate Bert Booth (R)
    11231 Greenspring Ave.
    Lutherville, MD 21093

14. Delegate Marilyn Goldwater (D)
    5508 Durbin Road
    Bethesda, MD 20014

15. Delegate Lucy Maurer (D)
    1023 Forest Glen Road
    Silver Spring, MD

16. Delegate Pauline H. Menes (D)
    7811 Riverdale Road
    Riverdale, MD 20040

Michigan-

17. Rep. Barbara-Rose Collins (D)
    2256 Leland Street
    Detroit, Michigan 48207

Minnesota-

18. Rep. Peggy Byrne (D)
    524 Van Buren
    St. Paul, Minnesota 55103

19. Senator Emily Ann Staples (D)
    1640 Xanthers Lane
    Plymouth, Minnesota 55391

Missouri-

20. Rep. Karen McCarthy Benson (D)
    1111 Valentine Road
    Kansas City, Missouri 64111

21. Rep. S. Sue Shear (D)
    District 76
    200 S. Brentwood
    Clayton, Missouri 63015

Nebraska-

22. Senator Shirley Marsh (R)
District No. 29
2701 South 34th Street
Lincoln, Nebraska 68506

23. Senator JoAnn Maxey (D)
District No. 46
2800 S. Street
Lincoln, Nebraska 68503

New Hampshire-

24. Rep. Ruth Nemzoff-Berman (D)
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25. Rep. Joanne Head (R)
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26. Rep. Susan McLane (R)
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New Jersey-

27. Assemblywoman Barbara A. Curran (R)
797 Springfield Ave.
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28. Assemblywoman Greta Kiernan (D)
62 Spring Street
Harrington Park, NJ 07640

29. Assemblywoman Rosemarie Totaro (D)
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New York-

30. Rep. Linda Winikow (D)
130 North Main St.
New City, NY 10956

North Carolina-

31. Rep. Louise S. Brennan (D)
2101 Dilworth Road
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32. Rep. Lura S. Tally (R)
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North Dakota-

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34. Rep. Corliss Mushik (D)
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Ohio-

35. Rep. Edith P. Mayer (R)
10120 Winstead Lane
Cincinnati, Ohio 45231

36. Rep. Donna Pope (D)
3915 Longwood Avenue
Parma, Ohio 44134

37. Senator Marigene Valiquette (D)
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218 East 29th Street
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40. Rep. Mary N. Kilmarx (D)
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42. Rep. Ernestine V. Glossbrenner (D)
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44. Delegate Eva F. Scott (I)
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Washington-

45. Senator Lois North (R)
    10126 Radford NW
    Seattle, WA 98197

46. Senator Ruth Ridder (D)
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    5809 S. Roxbury
    Seattle, WA 98118

Wisconsin-

47. Rep. Mary Lou Munts (D)
    125 West
    State Capitol
    Madison, WI 53702

The Washington Institute For Women In Politics

Of Mount Vernon College • 2100 Foxhall Road N.W. • Washington, D.C. 20007 • (202) 331-3418

Legislative Issues of the '70's From a Washington Perspective

A Workshop for State Legislators

PROGRAM

Thursday, May 25

11:00 am - 12:00 Noon — **Registration** ..... *Gate House and Post Hall*

12:00 - 1:30 pm — **Luncheon** ..... *Cafeteria*

Welcome and Orientation:

Dr. Susan J. Tolchin,
Director, Washington Institute for Women in Politics
Mrs. Esther Coopersmith,
Director of Development for the State Legislators Conference

Dr. Victoria Schuck
President, Mount Vernon College

A Roundtable: Background and Interests of Conference Participants

1:30 - 3:30 pm *Post Hall* — **The Importance of Consumer Protection at the State Level**

Moderator: Robert E. Juliano,
Legislative Representative, Hotel and Restaurant Employees and Bartenders International Union, AFL-CIO.

Speaker: Esther Peterson,
Special Assistant to the President for Consumer Affairs

Discussant: Alice Shabecoff,
Director, Neighborhood Relations Division, Office of Neighborhoods, Department of Housing and Urban Development.

3:30 - 5:00 pm *The Chapel* — **New Approaches to the CETA Program**

—Elements of Choice
—New Priorities
—Funding Levels
—Political Conflicts

Moderator: Carol Burris, – ann Schmitt
Director, the Women's Lobby

Speakers:
Susan Grayson,
Staff Director, Subcommittee on Employment,
U.S. House of Representatives

Richard E. Johnson,
Assistant to the Assistant Secretary, Department of Labor

Nanine Meicklejohn,
American Federation of State, County and Municipal Employees

6:00 - 8:00 pm — **Dinner** ..... *Cafeteria*

Current Federal Legislation Affecting Women

Speaker: Rep. Elizabeth Holtzman, (NY)
Cochair, Congressional Women's Caucus

Friday, May 26

9:30 - 11:30 am *~~Post Hall~~ The Chapel* — **Federal Expenditure Programs Affecting the States**

Moderator: Dr. A. Lee Fritschler,
Dean, College of Public Affairs, American University

Speakers:
Dr. Richard Nathan,
Senior Fellow, The Brookings Institution
"A Review of Urban Policy Issues"

John Callahan,
Director of State-Federal Relations,
National Conference of State Legislatures
"Education Seen as an Intergovernmental Transfer"

Discussant: Del. Lucille Maurer (MD)

12:00 - 1:00 pm — **Lunch** ..... *Cafeteria*

Federal Preemption

Speaker: Paul Sweet,
Staff Director, Congressional Relations,
National Conference of State Legislatures

1:30 - 3:30 pm *The Chapel* — **Developments in Health Legislation Affecting the States**

—Health Planning Legislation
—Medicaid
—Cost Containment
—National Health Insurance
—Reimbursement for Nurse Practitioners and other Related Health Professionals

Moderator: Nina Solarz,
Representative,
New York City Office in Washington

Speakers:
Robert Derzon,
Administrator, Health Care Finance Administration,
Department of Health, Education and Welfare

Rep. Marilyn Goldwater, R.N. (MD)

Karen Ignagni, – Harold Cooper
Assistant Executive Director,
Committee for National Health Insurance

Robert McGarrah,
Public Policy Counsel,
American Federation of State, County and Municipal Employees

4:14 - 5:00 pm — **Public Policy and Children:**
The Educational Dilemma

Speaker: Dr. Barbara Finkelstein,
Professor of Education,
University of Maryland

5:30-7:30 Post Hall – dinner The Pub

Saturday, May 27

9:30 - 11:30 am *~~Post Hall~~* Atchinson (left of cafeteria) — **Report of the President's Commission on Mental Health: Possibilities for New Federal-State Partnerships**

—Areas of Increasing Federal Support
—Fiscal Problems
—Program Considerations
—Potential for State Legislation

Moderator: Barbara Roffwarg, Esq.,
Former General Counsel,
New York City Dept. of Mental Health, Mental Retardation and Alchoholism Services;
presently a national consultant in health law

Speakers:
Dr. June Jackson Christmas,
Commissioner of Mental Health, Mental Retardation and Alcoholism Services for the City of New York

Discussant: Rep. Chris Miller (TX)

Mary Cunningham – AID (John Saunders) Population daughter – Tufts

This workshop was made possible by the following grants:

American Federation of State, County and Municipal Employees
Hotel and Restaurant Employees and Bartenders International Union
Martin Marietta Corporation
United Auto Workers

Conference Committee

Esther Coopersmith, ... *Development*
Ann Smith ..... *Public Relations*
Marilyn Montgomery ..... *Public Relations*
Valerie Duncan ..... *Operations*
Charlotte Resnick ..... *Operations*
Judy McLaughlin ..... *Operations*
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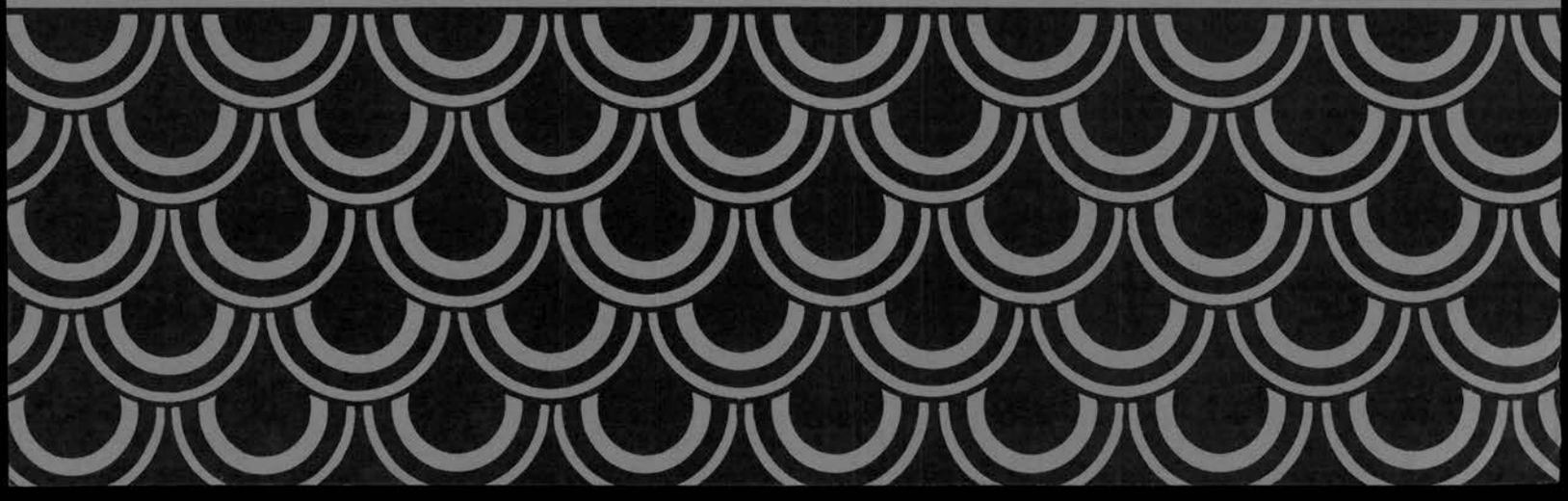
Legislative Issues of the '70's From a Washington Perspective



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LEGISLATIVE ISSUES OF THE '70's FROM A WASHINGTON PERSPECTIVE

A Workshop for State Legislators

PARTICIPANTS

Colorado -

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3. Senator Barbara D. Reimers (R)
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7. Rep. Donna R. Ikeda (R)
   7th Representative District
   State Capitol Room 415
   Honolulu, Hawaii 96814

8. Rep. Kathleen G. Stanley (D)
   State Capitol
   Honolulu, Hawaii 96814

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9. Rep. Sharon B. Benoit (D)
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12. Delegate Lucy Maurer (D)
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13. Delegate Pauline H. Menes (D)
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14. Rep. Barbara-Rose Collins (D)
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15. Rep. Peggy Byrne (D)
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16. Senator Emily Ann Staples (D)
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18. Rep. S. Sue Shear (D)
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New Hampshire -

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