

Responsibility. Everyone should contribute to health care. Right now, we all pay for those who don't take responsibility. It's time to say: "No one should get a free ride."

These six principles are the foundation of the Health Security Act of 1993.

The Health Security Plan is of particular benefit to African Americans because the burden of illness is especially great in the African American Community making universal coverage with comprehensive benefits imperative. African American' health status is lower than Americans as a whole. Life expectancy is lower, infant mortality is greater, many disabling diseases such as cardiovascular disease, diabetes, and arthritis are more common, yet a disproportionate number of the uninsured are African Americans. In addition, many African Americans rely on Medicaid or have bare bones policies. It does not make sense for people burdened with illness to be without comprehensive coverage.

Guaranteed Comprehensive Benefits

- The Health Security plan will guarantee all Americans comprehensive health care benefits they can never lose. Health alliances and plans are prohibited from discriminating on the basis of race, ethnicity, gender, religion, or country of origin.
- Alliances are prevented from creating two-tier systems of care, and a mechanism for redressing grievances quickly is required of all plans and alliances.

Community-Based Investments

- Community-based plans that can best address the needs of a particular community will be encouraged through special incentives, capital development programs, and public health initiatives.

Incentives for Providers

- New initiatives designed to expand access to care and encourage primary care will bring high quality medicine to millions of African- Americans who now live in medically underserved areas.
- The plan's health care workforce initiatives will increase funds for medical schools that train primary care doctors and expand the National Health Service Corp. The plan will increase the number of African-American physicians, nurses and other health professionals.

HEALTH CARE COVERAGE FOR AFRICAN-AMERICANS

The American Health Security Plan guarantees every American a comprehensive package of benefits that can never be taken. Health coverage will continue without interruption if you lose or change jobs, move from one area of the country to another, become ill, or confront a family crisis.

In many ways, African-Americans face a health care system stacked against them -- they are among the many Americans most at risk of going without care and coverage in today's system. Losing or changing jobs often means losing health insurance, and African-Americans have one of the highest unemployment rates in the country. The health of African-Americans is also aggravated by:

- *Violence. Homicide and legal intervention rates which are more than seven times higher among African-American males (61.5%) than white males (8.1%).*
- *Infant mortality rates. African-Americans rates are double (18.5%) those in white communities (8.1%).*
- *High mortality from preventable diseases -- heart disease, cancer, and stroke -- continue to plague this community.*

Security. Every American will receive a Health Security Card that guarantees you a comprehensive package of benefits that can never be taken away. If you lose your job, move, or get sick, you're covered. That's not true today.

Savings. To control health care costs we're going to spend smarter and make health plans compete for your business. We're going to cap how fast your health premiums can go up, eliminate wasteful spending, and crack down on fraud.

Quality. We're going to provide free preventive care, give you the information you need to choose, and invest in training more family doctors. We'll make what's best about American health care better.

Choice. We're going to preserve your right to choose your doctor. Many people, in fact, will have increased choices, including a traditional fee-for-service plan that too many of us are denied.

Simplicity. We're going to streamline the paperwork that's choking you and your doctors and nurses. Simplifying forms and cutting back on regulations will give doctors more time to spend caring for you.

Customer Satisfaction Surveys

- Health plans will conduct annual consumer surveys and must seek out those in communities that have historically been denied access to high quality care.

Community Representation

- Alliances will have a Board of Directors composed of equal numbers of consumers and employers who purchase care in that area. Each alliance will reflect the communities it serves.

September 21, 1993

NOTE TO Dr. Lavizzo-Mourey

FROM: Cheryl Smith *Cheryl*

Attached is a copy of the September 14, 1993, news release by the Congressional Caucus for Women's Issues where the Caucus introduced the Women's Health Equity Act of 1993. This bill is an omnibus legislative package containing 32 separate bills that focus on equality in research and health services. The bills contained in the act are introduced by different Caucus members.

Attachment

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Patricia Schroeder, Co-chair
 Olympia Snowe, Co-chair
 Cardiss Collins, Secretary
 Marcy Kaptur, Treasurer

Congressional Caucus for Women's Issues

Congress of the United States
 Washington, D.C. 20515

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Lesley Primmer
 Executive Director

Embargoed until
 September 14, 1993 at 9:30 a.m.

Contact: Lesley Primmer
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NEWS RELEASE

WOMEN'S CAUCUS CALLS FOR EQUITABLE TREATMENT OF WOMEN IN HEALTH CARE REFORM

As Congress prepares to debate health care reform, the Congressional Caucus for Women's Issues today unveiled a two-pronged effort to ensure equitable treatment for American women. Caucus Co-Chairs Reps. Patricia Schroeder (D-CO) and Olympia Snowe (R-ME) announced the introduction of a comprehensive legislative agenda on women's health and released a statement on behalf of the Caucus demanding that fairness and equity for women, including the provision of comprehensive reproductive health services, be a central feature of health care reform.

"Since the Caucus launched its women's health initiative three years ago, one fact has remained clear: whether we are talking about excluding women from medical research or giving short-shrift to research on breast cancer or contraception and infertility, women have been treated differently because of their reproductive systems," said Rep. Schroeder. "A health reform plan that continues to treat women as less than whole human beings may be worse than no reform at all," she added.

"We have a historic opportunity, as Congress considers fundamental reform of our health care system, to rectify glaring inequities in the conduct of health research and in the provision of services to women," according to Rep. Snowe. "Caucus initiatives to ensure the inclusion of women in medical research and to expand research on women's health have laid essential groundwork. But these hard-won successes will mean little if women's health care is isolated from other services under health care reform."

The Women's Health Equity Act of 1993 is an omnibus legislative package consisting of 32 separate pieces of legislation introduced by different members of the Caucus. The goal of the package is to set out a broad agenda for improving health care research and services for women. Issues addressed by the

package include AIDS research and prevention, a review of federal environmental risk assessment policies with respect to women, expanded testing of gender differences in new drugs approved by the FDA, as well as research on RU-486 and other antiprogestins. Other new initiatives are designed to improve medical school education on women's health issues, enhance federal smoking prevention efforts, and expand women's health research and services within the Armed Services and the Veterans Administration.

"No issue has resonated more strongly with American women over the past three years than the need for responsive and equitable treatment by doctors, health care facilities, and insurance companies," said Rep. Louise Slaughter, Chair of the Caucus' Task Force on Women's Health and the Environment. "We believe the 32 bills in this package are just the medicine that American women need."

First introduced in 1990, nearly a dozen WHEA provisions have become law including provisions to establish an Office of Research on Women's Health at NIH, require the inclusion of women and minorities in clinical research, increase research on breast and ovarian cancer, osteoporosis, and contraception and infertility. Other provisions enacted require Medicare reimbursement for screening mammography and put in place federal standards to ensure the safety and accuracy of the procedure, and create new programs to provide mammogram and pap smears to low-income women and prevent infertility through early screening and treatment for sexually transmitted diseases.

While it will be necessary to pass most of the provisions of the Women's Health Equity Act separately from health care reform, the Congresswomen were quick to point that the treatment of women's health in health care reform will be a major consideration for the Caucus. In a statement released by the Caucus today, the Congresswomen said that "the standard benefits package developed for any new health care system must include comprehensive reproductive health services, including abortion."

According to Rep. Nita Lowey, Chair of the Caucus' Task Force on Reproductive Choice, "The treatment of reproductive health services under health care reform is quite simply an issue of equal access to health care for women. Fairness and equity for women must be central to our consideration of health care reform."

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WOMEN'S ISSUES, CO-CHAIR

Congress of the United States
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STATEMENT OF REP. PATRICIA SCHROEDER (D-COLORADO)
CO-CHAIR OF THE CONGRESSIONAL CAUCUS FOR WOMEN'S ISSUES
SEPTEMBER 14, 1993

Women have suspected for years that they have second rate health care. However, it wasn't until the Caucus for Women's Issues documented inequities between men and women that the women in Congress had proof enough to change policies from the halls of NIH to the examination rooms of physicians.

Over the past four years, the Caucus has spearheaded the detective work that discovered how science and medicine, researchers and doctors treat men and women differently.

We found that the root of many of these differences had to do with women's reproductive systems. Simply put, women have been penalized in America's health care system and in medical research because we bear children.

Abortion politics, and many politicians' fears of becoming entangled in them, has so charged the debate around women's health that attention is often diverted away from one of our goals: comprehensive quality reproductive health care.

Women in America, and we as their voice in Congress, are adamant about making sure that health care reform is fair to women and gives them equal access to a full range of services, including reproductive health services.

Women know that a comprehensive, holistic system is the most effective health care system for them. You pull apart one part of that system, and the quality of women's care unravels.

That's why women who care about heart disease, breast cancer, AIDS, and osteoporosis will band together to make sure that women's health care remains seamless and that no part will become a bargaining chip.

You can't say that a plan is fair to women if reproductive health services are treated differently than other services.

The final definition of reproductive health services will ultimately define the final vote. If the final plan is unfair toward women, then there will be a significant proportion of the American public who will oppose the plan and I can assure you a block of votes--both Congresswomen and Congressmen-- who will rightfully reject it.



Congressional Caucus for Women's Issues

STATEMENT OF PRINCIPLE ON HEALTH CARE REFORM BY THE CONGRESSIONAL CAUCUS FOR WOMEN'S ISSUES

Historically, women's health has been treated as an afterthought. Women have been systematically excluded from medical research studies, received less aggressive treatment for heart disease and other serious conditions, and lacked access to important preventive services. The health care reform process that we are embarking upon gives us the opportunity to start fresh and to treat women as full citizens with equal access to the health care system.

Thus, as we form a new health care system, the Congresswomen will be paying special attention to ensure that women and men are treated equally. Improving access to comprehensive quality health care for all is vital for the health of our nation, but fairness and equity for American women must be central to our consideration of health care reform.

Using the standard of equal access to health care, women's health care, including reproductive health care, cannot be separated or isolated from other health services. The standard benefits package developed for any new health care system must include comprehensive reproductive health services, including abortion. Comprehensive reproductive health services include family planning services, pregnancy-related care, and post-reproductive care.

This is not a political debate over abortion or contraception — rather it is a critical debate over health equity for women. American women will be looking for leadership from the President and from the Congress to ensure that they are treated as whole human beings. As Congresswomen, we support a health care reform package that treats women's health equally to men's. We look forward to working with the President and our colleagues on a health care system that offers women equal access to comprehensive health care.



Congressional Caucus for Women's Issues

WOMEN'S HEALTH EQUITY ACT OF 1993

TITLE I – Research

- A) **NIH Women Scientists Employment Opportunity Act – Rep. Louise Slaughter** Requires the National Institutes of Health (NIH) to establish policies promoting the employment women scientists, to conduct a pay equity study, and to improve the visibility of women scientists.
- B) **Women and AIDS Research Initiative Amendments (H.R. 2394) – Rep. Constance Morella** Authorizes increased research on women and AIDS at the NIH, including studies on transmission, prevention, microbicides, and epidemiology.
- C) **Women and Alcohol Research Equity Act – Rep. Constance Morella** Expands research on women and alcoholism at the National Institute of Alcohol Abuse and Alcoholism.
- D) **National Breast Cancer Strategy Act (H.R. 615) – Reps. Marilyn Lloyd and Nancy Pelosi/ Sen. Barbara Boxer** Establishes a National Breast Cancer Commission, an interagency office on breast cancer, and authorizes \$300 million for increased breast cancer research at the NIH.
- E) **Lupus Research Amendments (H.R. 2420) – Rep. Carrie Meek/ Sen. Carol Moseley Braun** Authorizes \$20 million in additional funding for research on Lupus at the National Institutes of Health.
- F) **Midlife Women's Health Research Act (H.R. 2842) – Rep. Marilyn Lloyd/ Sen. Barbara Mikulski** Establishes 5 regional centers as model programs for research, education and health care delivery for midlife women.
- G) **Osteoporosis and Related Bone Disorders Research, Education and Health Services Act (H.R. 1844) – Rep. Olympia Snowe/ Sen. Charles Grassley** Authorizes \$62 million to expand and coordinate federal research on osteoporosis.
- H) **Ovarian Cancer Research and Information Act (H.R. 2810) – Rep. Patsy Mink** Authorizes increased basic and clinical research on ovarian cancer, and provides for a public and patient information program on the risks and treatments for ovarian cancer.
- I) **Antiprogesterin Testing Act of 1993 (H.R. 437, S. 222) – Reps. Ron Wyden and Patricia Schroeder/ Sen. Paul Wellstone** Authorizes research on RU-486 and other antiprogesterins at the National Institutes of Health for all of its potential uses.
- J) **Women's Health Environmental Factors Research Act of 1993 – Rep. Elizabeth Furse** Authorizes a \$30 million increase in appropriations to the National Institute on Environmental Health Sciences for research on the impact of environmental factors on women's health.
- K) **The Federal Risk Assessment in Women's Health Act of 1993 – Reps. Louise Slaughter and Elizabeth Furse** Calls for an interagency review on environmental risk assessment policy in women's health, including exposure standards for pollutants and pesticides, and their impact on women's health. It authorizes a study by the National Academy of Science to determine the science base and research needs.
- L) **Pharmaceutical Interactions Safety Act (H.R. 2694) – Reps. Patricia Schroeder and Olympia Snowe/ Sen. Barbara Mikulski** Requires drug companies to study the interaction of new drugs with hormones, such as hormone replacement therapy or oral contraceptives, prior to approval by the Food and Drug Administration.
- M) **Pharmaceutical Testing Fairness Act (H.R. 2695) – Reps. Patricia Schroeder and Olympia Snowe/ Sen. Barbara Mikulski** Requires drug companies to include women in clinical studies, and to examine gender differences

in Phase 3 clinical trials when testing new drugs for approval by the Food and Drug Administration.

N) Tobacco Advertising and Promotion Studies Act – Reps. Lucille Roybal-Allard and Cardiss Collins Requires the Federal Trade Commission to carry out a study on cigarette advertising targeted toward women and minorities.

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TITLE II -- Services

A) Health Professional Education In Women's Health Act -- Rep. Nita Lowey/ Sen. Barbara Mikulski Requires the Public Health Service, including HRSA and NIH, to conduct a study on incorporating women's health in health professional curricula and training.

B) Women's Health Offices Act -- Rep. Olympia Snowe/ Sen. Barbara Mikulski Establishes Offices of Women's Health at the FDA, the Agency for Health Care Policy and Research, HRSA, and CDC.

C) Women's Health Information Act -- Rep. Marilyn Lloyd Establishes an interagency working group on women's health communications in the Public Health Service to improve the development and dissemination of health information for women. It establishes a clearinghouse on women's health, and directs the Agency for Health Care Policy and Research to evaluate the effectiveness of health communication efforts.

D) Breast and Cervical Cancer Mortality Prevention Act Reauthorization (S. 1310, H.R. 2202) -- Sen. Barbara Mikulski/ Rep. Henry Waxman Reauthorizes the Breast and Cervical Cancer Mortality Prevention Act which provides grants to states for mammograms and pap smears for low income women.

E) Women's Preventive Health Amendments (H.R. 2158) -- Reps. Rosa DeLauro and Olympia Snowe Establishes 3 demonstration projects expanding the Breast and Cervical Cancer Mortality Prevention program to include other preventive health services.

F) Post-Reproductive Health Care Act (H.R. 1492) -- Rep. Marilyn Lloyd Provides grants to family-planning clinics, and other clinics serving low-income women, to offer counseling and services on midlife health issues.

G) Medicare Bone Mass Measurement Coverage Act (H.R. 954) -- Rep. Olympia Snowe/ Sen. John Glenn To provide Part B Medicare coverage of bone mass measurement for women at risk of osteoporosis.

H) Mickey Leland Adolescent Pregnancy and Parenthood Act -- Rep. Nancy Johnson/ [REDACTED] Revises the Adolescent Family Life Act (AFLA) to provide for pre- and post-natal care, well-baby and well-child care, family planning services, and parenting education.

I) Adolescent Health Demonstration Projects (H.R.129) -- Rep. Cardiss Collins Increases access to health care services by providing grants for adolescent health demonstration projects in secondary schools. Requires family participation, local school board approval, and a community advisory board.

J) Eating Disorders Outreach and Education Act -- Rep. Patricia Schroeder Establishes an information and education program at the Center for Mental Health Services, and a toll free hotline for the prevention and treatment of eating disorders.

K) Women and HIV Outreach and Prevention Act (H.R. 2395, S. 1428) -- Rep. Constance Morella/ Sen. Paul Simon Establishes a grant program to provide funds for prevention, education and substance abuse treatment targeted to women at risk for HIV infection.

L) Standby Guardianship Act (H.R. 1354) -- Rep. Carolyn Maloney Requires states to develop laws so that chronically ill parents could choose standby guardians for their children without giving up parental rights.

M) Federal Prohibition of Female Genital Mutilation Act -- Reps. Patricia Schroeder and Barbara Rose Collins Prohibits the practice of female circumcision, excision, or infibulation in the U.S. and directs the Dept. of HHS to provide education and prevention activities.

N) Smoking Prevention and Cessation in WIC Clinics Act -- Reps. Karen Shepherd and Eddie Bernice Johnson Establishes demonstration projects at clinics for the Women, Infant and Children nutrition program to provide smoking prevention and cessation activities for women.

O) Sense of Congress Resolution that any health care reform proposal include FMLA as a basic or elective option (H.Con Res.377) -- Rep. Marcy Kaptur Would expand availability of Family Medical Leave to all employees by making it an elective option of health insurance which can be purchased by beneficiaries

A an elective option of health insurance which can be purchased by beneficiaries.

P) Veteran Women's Health Improvement Act (H.R. 2797) -- Reps. Patricia Schroeder and Marilyn Lloyd
Establishes women's health services and research within the Veterans Administration health system.

Q) Defense Women's Health Improvement Act (H.R. 2715) -- Reps. Patricia Schroeder and Marilyn Lloyd
Establishes women's health services and research within the Armed Services health system.

R) International Population Stabilization and Reproductive Health Act (H.R. 2447, S. 1096) -- Reps. Anthony
Bellenson and Constance Morella/ Sens. Jeff Bingaman and Alan Simpson Establishes and strengthens policies and
programs for the early stabilization of world population through expanded family planning programs and reproductive
choice.

Pisa

Racial Equity in Renal Transplantation

The Disparate Impact of HLA-Based Allocation

Robert S. Gaston, MD; Ian Ayres, JD, PhD; Laura G. Dooley, JD; Arnold G. Diethelm, MD

KIDNEY transplantation from either a living related or cadaveric donor is optimal treatment for most patients with end-stage renal disease (ESRD).¹ However, due to a critical shortage of organ donors, while more than 23 000 Americans await a suitable cadaveric kidney, fewer than 8000 receive transplants each year.^{2,3} Approximately one third of ESRD patients in this country are African American (black), a proportion threefold greater than the representation of this racial group in the general population (12%).¹ Recently, the Inspector General reported that blacks are less likely than whites to receive a transplant, with almost double the waiting time.⁴ Currently, cadaveric kidneys are allocated according to a federally mandated system based on quality of HLA matching. This policy is based on evidence that antigenic similarity between donor and recipient may enhance cadaveric graft survival and should be the primary factor influencing distribution.⁵ Gjertson and colleagues⁶ have proposed that there be even greater emphasis on HLA matching in organ allocation, with all cadaveric kidneys to be placed in a single national pool and distributed to the transplant candidate with the "best" HLA match. In the face of a critical (and growing) shortage of transplantable kidneys, current directives place potential black recipients at a significant disadvantage; extension of HLA-based allocation will magnify racial disparity. We

contend that all suitable renal transplant candidates should have equitable access to cadaveric kidneys. To the extent that HLA matching demonstrably improves survival of cadaveric renal allografts, it is an efficient means to effect difficult allocative choices. But, given its documented negative impact on black ESRD patients, the system must be reevaluated to determine whether the cost in equity is truly justified. A recent editorial suggested that "every kidney counts"; we submit, rather, that every patient counts.

RACIAL DISPARITY IN ESRD AND TRANSPLANTATION

Minority populations in the United States (American Indians, African Americans, and Hispanics) are at increased risk of developing ESRD relative to whites.⁸ Blacks are numerically the largest of these minorities and also have the highest incidence of chronic renal failure.² Since 1972, Congress, under the auspices of Medicare, has funded ESRD therapy for most Americans, in the form of either long-term dialysis or renal transplantation.⁹ A successful kidney transplant imparts several advantages to the recipient, who is more likely to avoid hospitalization, experience a greater sense of well-being, return to the workforce, and, perhaps, live longer than with dialytic therapy.¹⁰⁻¹² Additionally, after the first year, the costs of caring for a transplant recipient are roughly one third of those associated with long-term dialysis.¹ According to a review of the favorable impact of transplantation on the Medicare ESRD program, "Trends in transplantation have not yet had much effect on black beneficiaries... [who]... were receiving transplants at only half the rate of white beneficiaries."¹ Indeed, 1989 figures from

the US Renal Data System (USRDS) revealed white dialysis patients to be more than twice as likely as black patients to receive a kidney allograft (8.3% vs 3.9%).² Kidneys from living, usually related, donors constitute 20% of all transplants.² Blacks desiring transplantation are, for poorly defined reasons, less likely than whites to have a suitable living donor and are relatively more dependent on availability of cadaveric kidneys. However, despite their constituting 31% of patients on waiting lists, blacks received only 22% of cadaveric kidney transplants in 1990, with a median waiting time of 13.9 months vs 7.6 months in whites.^{4,13} Among American Indians, rates of transplantation are comparable to those for whites; data regarding Hispanic patients are incomplete.¹⁴ Thus, the impact of disparity in transplantation is greatest for African-American patients.

Possible causes of racial disparity in cadaveric transplantation are numerous, to be sure, and have been the subject of a recent review.¹⁴ Black patients in the southeastern United States may be less likely than whites to be referred for transplantation.¹⁵ Although the waiting list at the University of Alabama at Birmingham reflects local ESRD demographics (65% African American), national data support this finding: blacks, despite receiving fewer living related transplants, are relatively underrepresented on cadaveric waiting lists.⁴ Moreover, when a cadaveric kidney becomes available, socioeconomic circumstances may limit the ability of potential black recipients to communicate with or travel to the transplant center in a timely fashion.¹⁶ Nevertheless, organ allocation policy, a previously unacknowledged factor, plays a key role in perpetuating disparate racial access to cadav-

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eric kidneys and, therefore, to transplantation.

ORGAN ALLOCATION IN THE UNITED STATES

The National Organ Transplantation Act (Public Law 98-507) of 1984 mandated creation of an Organ Procurement and Transplantation Network (OPTN), charged with establishing (1) "a national list of individuals who need organs," (2) a national system "to match organs and individuals included in the list," and (3) "membership criteria and medical criteria for allocating organs."¹⁷ A pre-existing entity, the United Network for Organ Sharing (UNOS), was awarded the OPTN contract under the auspices of the Department of Health and Human Services. After 1986, UNOS operated as the OPTN. Under penalty of losing all Medicare funding, the Omnibus Budget Reconciliation Act (Public Law 99-509) of 1986 mandated compliance of organ procurement organizations and transplant centers with UNOS directives.¹⁷ Congress charged UNOS with acquiring and allocating all usable organs "equitably among transplant recipients according to established medical criteria"; accordingly, UNOS developed guidelines affecting kidney allocation at both the local and national levels.

A 1987 UNOS ruling stipulated that if a potential recipient shared all six antigens identified at the HLA-A, HLA-B, and HLA-DR loci with any cadaveric donor, "it is mandatory that the kidney shall be offered for the six antigen patient."¹⁸ Multicenter data had indicated that excellent graft survival could be expected for such recipients; to facilitate outstanding matches, a large donor-recipient pool would be required.^{19,20} For the first time, nationwide organ sharing was mandated. Enhanced graft survival for six-antigen-matched recipients (who receive <5% of all cadaveric transplants) was determined to outweigh all other claims on a donated organ and to justify the excess cost and effort required to transport kidneys on a national level.²¹ Recently, an identical "six-antigen match" was effectively redefined as phenotypically identical ("zero-antigen mismatch"), extending mandatory sharing to a greater number of harvested kidneys.²² Graft survival has indeed been excellent (88% at 1 year) in 1004 recipients of mandatorily shared kidneys using both definitions. However, successful engraftment was also achieved in 79% of 22 188 recipients of mismatched kidneys during the same time period.^{23,24}

If a donated kidney fails to qualify for mandatory sharing (no six-antigen-matched patient exists), organ allocation occurs at the "local" level, as de-

United Network for Organ Sharing Point System for Kidney Transplant Recipient Selection (1989)

	Points
HLA matching	
No A, B, DR mismatch	10
No B, DR mismatch	7
No A, B mismatch	6
1 B, DR mismatch	3
2 B, DR mismatches	2
3 B, DR mismatches	1
Presensitization	
Panel reactive antibodies $\geq 80\%$ (negative crossmatch)	4
Waiting time	
Patient with longest waiting time (proportionate fractions of 1 point to patients waiting shorter periods)	1
Each year on waiting list	0.5
Age of children, y	
0-5	2
6-10	1

finer by individual organ procurement organizations. The first attempt to standardize local allocation was the adoption of the "Starzl system" in 1987: "points" were awarded to potential recipients on the basis of quality of HLA match, waiting time, degree of presensitization (presence of anti-HLA antibodies), "medical urgency," and logistic factors such as proximity to the transplant center.²⁵ The candidate on the local waiting list with the greatest number of points for a particular donated kidney was offered the organ. In 1989, the "Terasaki modification" supplanted the initial algorithm.²⁶ This revision deleted proximity and urgency as factors and placed greater emphasis on quality of HLA match (Table). Under this system, although other factors (such as age and presensitization) impact the selection process, HLA match is the principal determinant of kidney allocation, with waiting time serving largely as a tiebreaker. For example, a patient with only a single antigen matched could conceivably be given priority for a particular kidney over zero-matched candidates who had waited up to 2 years longer. In the absence of a UNOS-approved alternative plan (termed a variance), all local entities are required to allocate kidneys on this basis.⁵

RACIAL IMPACT OF HLA-BASED ALLOCATION

Despite striking advances in technology, characterization of the major histocompatibility complex (MHC) in humans remains incomplete. It is clear that profound racial differences exist in antigen expression. Blacks have less well-defined HLA antigenic specificities than do whites, particularly at the DR locus.^{27,28} Furthermore, HLA antigens are distributed differently among races.²⁹ For example, at the A locus, HLA-A1 is found in 23% of whites, but only 10% of blacks; conversely, HLA-A23 is much

less common in whites (6%) than blacks (22%). Newer histocompatibility approaches, including molecular and epitope matching, by defining more precisely MHC and its products, have demonstrated better correlation of HLA matching with graft survival.^{30,31} However, application of these techniques has confirmed the presence of even greater heterogeneity in MHC expression.

When current methodology is considered (ie, serological typing for six A, B, and DR antigens), along with other factors such as linkage disequilibrium, histocompatibility exerts a significant racial impact on organ allocation: the closer the match, the less likely a kidney will cross racial lines.^{32,33} Lazda and Blaesing³³ examined the quality of the HLA match between 352 cadaveric donors (86% of whom were white) and a waiting list of potential recipients who were 51% white. Over 70% of potential recipients for whom at least four of six antigens matched were white. These investigators have also noted the rarity of kidneys crossing racial lines with fewer than four mismatched antigens.³⁴ Emphasis on HLA matching in distribution of cadaveric kidneys disfavors interracial transplantation, a fact acknowledged by proponents of HLA-based allocation.²⁴

Accordingly, allocation based on HLA matching promotes racial disparity in access to renal transplantation in the United States. Only 8% of cadaveric kidneys come from black donors; whites donate the overwhelming majority of such organs.² Lazda and Blaesing³³ concluded that "... using HLA matching to allocate kidneys from a predominantly Caucasian donor population favors the Caucasian recipients and places ... blacks at a disadvantage." The racial consequences of HLA-based allocation are confirmed by data derived from mandatory sharing of six-antigen-matched kidneys. Of true six-antigen-matched recipients, initial reports documented fewer than 2% as black.²³ Since the incorporation of a phenotypic definition of six-antigen match, this proportion has increased to 7%.²⁴ At the University of Alabama at Birmingham (with a waiting list that is 65% black) only one of 33 kidneys shipped or received as part of the six-antigen-match program has been for a black patient.²⁶ Data from UNOS confirm that blacks receive six-antigen-matched kidneys at one-tenth the rate of whites.³⁵ Hunsicker and Held³⁷ have estimated that mandatory national sharing of all kidneys with no HLA mismatches would result in a maximum of 8% going to black recipients, with a net overall effect of reducing by 3 percentage points the number of kidneys available for all black candidates. Fur-

ther, at the local level, white patients receive the vast majority of kidney transplants with excellent donor-recipient histocompatibility.^{13,14,28} It is not uncommon to see white candidates receive transplants within weeks of placement on the waiting list, solely because they demonstrate common HLA antigen specificities. Indeed, black patients' receiving transplants may actually be facilitated by a small waiting list; a larger list may include more potentially well-matched (ie, white) candidates.

Proponents of HLA-based allocation have suggested further extension of mandatory sharing, with all cadaveric kidneys offered to the candidate with the "best" HLA match on a national basis.⁶ They argue that graft survival will be maximized, fewer patients will require retransplantation, and, therefore, more kidneys will be available for those remaining on waiting lists. The potential racial impact of such a policy is not addressed directly, but a "trickle-down" benefit for blacks is suggested as white patients with common HLA antigens receive transplants and are removed from waiting lists. However, in the presence of an organ shortage, with a threefold (and growing) excess of potential recipients, along with racial disparity in MHC expression, there will always be white patients who match the donor population better than black patients. In theory, this discrepancy might be ameliorated by increased organ donation from African Americans.^{16,21,33} Blacks may be relatively underrepresented as donors; more African-American donors would mean more well-matched kidneys for black transplant candidates. Although such a solution is attractive, the demographic reality is that, due to overrepresentation of blacks in the ESRD population, there will always be more potential black recipients than donors. Organ donors originate within the general population. In Alabama, blacks make up 24% of the population, 21% of cadaveric donors, yet 65% of those awaiting renal transplants.³⁰ Nationally, blacks constitute 12% of the population, 8% of donors, but 34% of those with ESRD.² To satisfy the demand of African-American candidates for well-matched kidneys, organ donation from blacks must increase by 500%, to a standard far in excess of realistic goals and donation rates within the white community. Although we emphatically support efforts to promote organ donation among blacks (and whites), increased donation by African Americans is not the sole solution to racial disparity in renal transplantation. Moreover, the presumed (though difficult to confirm) lack of participation by black Americans

in the organ donation process does not justify policies that enhance access for individual white ESRD patients relative to individual black patients.

EQUITY AND EFFICIENCY IN ORGAN ALLOCATION: RACIAL IMPLICATIONS

As we have noted, the original charge to UNOS was to allocate organs "equitably among transplant recipients according to established medical criteria."¹⁷ Current policies stress the latter portion of this charge by emphasizing quality of HLA match in an attempt to improve transplant outcomes; efficiency is the goal. The Inspector General's report, recognizing disparity in the process, recommends that the Public Health Service, in collaboration with the OPTN, "... distribute donated organs to those patients on a first-come first-served basis, subject to established medical criteria."¹⁴ Equity is thus restated as a primary objective in organ allocation; however, a pure equity-based system, or queue, risks ignoring factors that may have an impact on success rates in transplantation. In both statements, the tension between equity and efficiency centers on the significance of the term "medical criteria." One must then assess whether the benefit of HLA matching in enhancing efficiency is sufficiently great to override equity concerns.⁴⁰

Allocation based on HLA matching is rooted in evidence that antigenic similarity between donor and recipient may enhance graft survival; thus, the most efficient use of a donated organ requires excluding from transplantation those candidates less likely to have a good result (ie, those with a poorer match). Clear correlation between HLA match and outcome is well documented in living related transplantation, where phenotypic matching is a proxy for underlying genetic similarity.¹⁹ However, in cadaveric transplantation, with genetically diverse donors and recipients, benefit from matching is less well defined.⁴¹⁻⁴⁴ In the cyclosporine era, outcomes appear to be improved for recipients of extremely well-matched cadaveric transplants: a difference in graft survival of 10 to 14 percentage points at 2 years between best (no mismatches) and worst (completely mismatched) donor-recipient pairs is generally accepted, and confirmed by data from the six-antigen-match program.⁴⁴ However, incremental changes in graft survival as one moves from six (completely mismatched) to one mismatch are at most 1 to 3 percentage points and are inconsistently documented.^{36,44} Indeed, USRDS data, derived from Medicare records, demonstrate little statistical re-

lationship of HLA match to survival of first allografts at 5 years in the presence of one or more mismatches.⁴⁷ For black recipients of first grafts, there is no consistently documented benefit of HLA matching on graft survival.^{23,45,46} According to data from the UCLA Transplant Registry, matching may not be a significant prognostic factor for black recipients.⁴⁷⁻⁴⁹ In a recent review of UNOS data, Cicciarella and Cho⁵⁰ state that "black transplant recipients show little or no matching effect when HLA-A, B, and DR antigens matched." Indeed, subsequent data from the UNOS Registry do not indicate significant improvement in graft survival even for black recipients of phenotypically identical grafts.²⁴ In retransplantation, which occurs in a more complex immunologic milieu, quality of match may assume greater significance.^{37,44,50} Thus, the benefits of allocation based on HLA matching are neither uniform nor unequivocal: its greatest influence occurs in white recipients of phenotypically identical kidneys. Enhanced efficiency for other potential recipients, as well as for the "system," is undocumented.

Moreover, enhanced efficiency is not and cannot be the singular objective of organ allocation. If it were, one could compellingly argue that blacks be completely excluded from cadaveric transplantation. To maximize efficiency, any discount in graft survival may be sufficient for exclusion. An 8- to 19-percent-age-point decrement in graft survival for blacks relative to whites is well documented^{2,45,47} and quite similar to differences in outcome between extremely well-matched and poorly matched transplants. Allocation of kidneys to whites only (as occurs indirectly in the six-antigen-match program) might therefore enhance graft survival equally as well as hierarchical HLA matching. Efficiency also has a financial context. Gjertson and colleagues⁶ suggest that hierarchical HLA-based allocation would potentially save Medicare \$6.5 million over 5 years: improved graft survival would more than offset the additional costs derived from matching, preserving, and transporting kidneys nationwide. However, exclusion of blacks from cadaveric transplantation, based on racial differences in graft survival, might save even more money. Extending the analysis of Gjertson and colleagues, with hazard rates derived from Opelz and associates,³¹ the estimated 5-year average cost of a transplant (including return to dialysis in the event of graft failure) is \$98 300 for a black recipient and \$90 700 for a white recipient. Reallocating to whites the approximately 1400 cadaveric kidneys that annually go to black

recipients might save an additional \$10.6 million. Obviously, direct racial exclusion to enhance efficiency in either cost or graft survival is morally and ethically unacceptable. The drive for efficiency must be tempered by a more sophisticated policy of accommodation in kidney allocation.

EQUITY AND EFFICIENCY: ACCOMMODATION

If there were no effect of variables such as race and matching on transplant outcomes, tension between equity and efficiency would be eliminated. Recent advances in renal transplantation hold the promise of such nonexclusionary efficiency. Data from several centers have shown graft survival for all recipients of first grafts, regardless of HLA match, to equal those reported in multicenter data for only the best matches.⁴² These results have accrued with quadruple immunosuppression, a regimen that combines administration of four potent agents (Minnesota antilymphoblast globulin, cyclosporine, azathioprine, and corticosteroids) in a sequential fashion. At the University of Alabama at Birmingham, this protocol has abrogated racial differences in primary allograft survival over 3 years, despite significantly poorer HLA matching in blacks,⁴³ a finding confirmed by others.⁴² Newer, perhaps more effective and less toxic immunosuppressants (FK506, RS61443, rapamycin, and 15-deoxyspergualin) and monoclonal antibodies (anti-ICAM-1) are on the horizon with the potential to further diminish the impact of HLA matching on graft survival.⁴³⁻⁴⁷

Despite emphasis on HLA matching to enhance efficiency, current UNOS policies already accommodate equity in some circumstances. A relatively lengthy waiting time for patients of blood type O (universal donor) was thought to reflect the practice of offering kidneys with a better HLA match to an ABO-compatible recipient.⁴⁸ As a remedy, UNOS policy was amended to specify that O kidneys be offered only to O recipients (except in the presence of a six-antigen match). Thus, transplant candidates with type O blood are offered equal access to cadaveric kidneys despite the potential of better HLA matches in patients with other ABO types.⁴² Furthermore, patients who are highly sensitized to HLA antigens (a situation that limits their ability to accept kidneys from potential donors) receive points to enhance equity, despite the knowledge that sensitization is a risk factor for graft loss.⁴⁹ Finally, children, who have poorer graft survival than adults, receive additional points to enhance access to renal transplantation.⁵⁰ In each of these situations,

some efficiency is sacrificed to achieve greater equity.

Accommodation between the competing goals of racial equity and efficiency, while elusive, is nonetheless attainable. Preference for HLA matching should be given only in proportion to its documented effectiveness in improving graft survival, that is, in extremely well-matched recipients (usually white) and retransplant candidates. Mandatory sharing of phenotypically identical kidneys should continue: its utility is supported by a well-defined dividend in graft survival, and relatively few kidneys (<5%) are removed from the overall cadaveric pool.²³ Kidneys not qualifying for mandatory sharing would continue to be allocated locally; partial matching would be deemphasized, with no points awarded when more than one B or DR antigen is mismatched. If no well-matched candidate is identified for a donated kidney, a policy to enhance allocation to black recipients should be implemented.

A local variance that moves toward more equitable allocation is currently undergoing evaluation in Illinois.⁵⁰ Points are awarded only for "excellent" HLA matches, and waiting time is given greater emphasis. While this algorithm enhances black patients' access to kidneys and preserves the efficiency of outstanding matches, its implicit race consciousness does not address the disparity in waiting times between blacks and whites. In fact, it may exacerbate the problem: prolonged time on the list is required for black patients to accumulate enough "points" to offset the advantage to whites of better matching. Thus, although data are not yet available, the Illinois variance avoids specific reference to race but may perpetuate inequity in waiting times.

An alternative proposal might recognize more explicitly the racial implications of HLA-based allocation and award points to blacks without requiring excessive waiting time. "Race-conscious points" could be used to compensate for points accumulated by whites on the basis of HLA matching. Such a plan offers reduced racial discrepancy in both frequency of transplantation and waiting times, with maintained efficiency for well-matched recipients. Its principal liability is explicit race consciousness, a factor that may conflict with other social norms: race, a concept based primarily on skin color rather than physiological difference, must be defined.⁴¹ Realizing the arbitrary nature of any definition, we would propose a simple one: allow transplant candidates to define their own racial origin, much as is currently done in collecting USRDS and

UNOS data.^{2,44} Thoughtful dialogue is necessary to further refine such a radical solution. Nevertheless, an approach that openly confronts racial differences may be required, at least temporarily, if equity is to be achieved.

CONCLUSION

The equitable and efficient distribution of limited resources, such as cadaveric kidneys, requires careful evaluation of all the effects of allocative choices that are made. In this essay, we have focused, perhaps simplistically, on the racial impact of allocation policies: clearly, race is not the sole issue impacting organ allocation. However, HLA-based allocation is equally simplistic in the assumption that universal benefit will result from better matching. The truth is that some will benefit, and others will not. Disproportionate representation of African Americans in the ESRD population dictates that racial considerations cannot be ignored in the distribution of cadaveric kidneys in the United States. Efforts to increase black donation are to be encouraged but will not eliminate disparity. If racial equity in renal transplantation is to be achieved, alternative allocation strategies must be formulated that forthrightly address the interests of all potential recipients.

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With the Clinton administration's focus on grassroots communication, local newspaper op-eds are a very effective way to get your medical society's voice heard. You can help influence public opinion by writing to your local newspaper editor about how the Clinton plan will affect patients.

Following is a sample op-ed piece. Whether you use it verbatim, adapt it or compose your own, the AMA encourages you to let your local newspaper editorial boards know your society's views on health system reform.

Sample op-ed

THE PRESIDENT'S RX FOR HEALTH CARE: LET'S GET A SECOND OPINION

I am a physician, and I think my patients need to get a second opinion before we all rush to accept the prescription President Clinton has offered for what ails our health care system.

Ever since I took my Hippocratic Oath as a young medical student, my pledge has been to fight for what is best for my patients. As a doctor, this is the litmus test I apply to the President's plan: It must put my patients first.

Not long ago this debate was about access and quality of care. That is when I was full of hope. A guarantee that everyone will have access to quality, affordable health care -- no matter who you are or where you are -- are basic rights my patients deserve.

But in the past year the focus shifted. Today the debate is more about economics and deficit reduction, about dollars first and patients second.

I can't help but feel it is the men and women and children I care for who are getting lost in the rhetoric the nation is hearing from Washington.

What I am not hearing are the right answers to these questions:

- * Will the quality of care be as good as it is today?
- * Will my patients have the same freedom to choose their own doctor?
- * And will the mutual doctor-patient trust that is the heart and soul of medicine remain unbroken?

When I looked through the President's plan for the answers, my hope faded. This is a plan loaded with price controls, new layers of bureaucracy and more regulation. The document itself is more than 250 pages long, and by the time I reached Page 70, I had counted five new agencies in the making.

It seems as if they all have one mission: To set the bottom line before I even see my patient. If my government forces me to trade my stethoscope for a calculator, my patients will lose.

I am worried, too, that the means to finance reform is murky. The short-term solution President Clinton wants would have us dip into Medicaid and Medicare programs for the poor and elderly to come up

Most of the country's leading economists warn that the President's expectations are too high and the savings won't materialize. When that happens, they predict, the only recourse will be to cut medical services for everyone, and that will defeat what reform is supposed to be all about in the first place.

Like any complicated scientific or medical problem, it is obvious there will be no quick and easy cure to a problem so enormous it affects an entire nation.

I am sworn to advocate what is best for my patients. Reform is too important not to do it right. This may be the only chance we will have in my lifetime to bring about the fundamental changes patients and physicians need.

President Clinton is prescribing a stiff dose of medicine that is brand new. We need to be absolutely sure there are no dangerous side effects before we agree this is the best course of treatment.

To: Dr. Risa Lavizza-Mourey and Pat Longus
Phone: (301) 594-6662
From: Jess Sarmiento
Office of Media Affairs
Phone: 456-7150 rm. 165

This is a list of the Mississippi media that will be connected to the conference call on 10/20/93 at 11:30am.

Clarion Ledger
Susie Spear
601-961-7266

North East Mississippi Journal
Bobby Harrison
601-842-2611 ext 261

Laurel Leader Call
Hal Marx
601-428-0551 ext 39

Starkville News
Shep Montgomery
601-323-1642

Oxford Eagle
Dave Magee
601-234-4331

Times Leader
Patty Archer
601-494-1353

Thank You!

President

713 - 461 3054



THE WHITE HOUSE

OFFICE OF MEDIA AFFAIRS

FAX: (202) 456-6409

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TO: Pat Longus

FROM: 301 594-2168

RECEIVER FAX: Michele Battalione

RECEIVER PHONE: _____

NUMBER OF PAGES (INCLUDING COVER SHEET): 2

COMMENTS:

Hegervy (206)-624-0562
Chaba Hegervy

John Olsen 386-3150



what happens when

SSM A crosses state
lines

What

will

9/14/93

TO: Risa Lavizzo-Mourey, MD

FROM: Carolyn Clancy, MD

Attached is a brief description of the JAMA study. I also attached a copy of an article from Newsday since I wasn't completely clear for whom the information was intended, and in what format it would be most useful.

Thanks for thinking of it.

PHOTOCOPY
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NEWSDAY

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Uninsured Die Younger, Study Says

By Dena Bunis

STAFF WRITER

Whether you're rich or poor, old or young, a college graduate or dropout, if you don't have health insurance the chances you will die prematurely double, according to a national study published today.

The study, published in the *Journal of the American Medical Association*, concluded, after analyzing more than 15 years of data on nearly 5,000 people, that 18.4 percent of those who began the study without insurance had died compared to a death rate of 9.6 percent for those with insurance.

One of the most wrenching issues likely to face lawmakers this fall when the country begins to debate the overhaul of the health care system will be

how quickly to cover the estimated 40 million uninsured Americans.

Some say universal coverage will be universal coverage until others suggest the nation cannot afford that until runaway health costs are brought under control.

These results pose a challenge to people who want to delay universal access, said Dr. Carolyn Clancy, director of the division of primary care at the federal Agency for Health Care Policy and Research, and one of the three authors of the University of Rochester-based study. "These results would suggest that providing universal access sooner than later will actually have an important effect on people's lifespans."

What makes this study different from previous analyses of the plight of

American uninsured, experts say, is that the study controlled for such factors as race, income, education, employment and such health risk factors as alcoholism and obesity. Even with those factors accounted for, not having insurance posed a significant threat to mortality.

Karen S. Davis, executive vice president of the Commonwealth Fund, a New York-based philanthropy, said the Rochester study confirms what other investigators have found.

The study released a survey of women's health, and 38 percent of uninsured women reported not getting medical care when they needed it, Davis said. "I think people either don't get care or they delay care when there's a financial barrier to getting that care."

Health officials often point out that

hospital emergency rooms don't turn away the gravely ill.

"Yes, people get medical care, but at what stage and how rescuable are they?" said Dr. Marthe Gold, a family practitioner and University of Rochester researcher. "I have had many patients who wait an awful long time to get care because there's nothing to pay their bill and it doesn't feel so awful or the jump didn't seem to be getting all that much bigger."

One pitfall of the study, a critic suggested, was that the participants' health insurance status was only checked at the beginning of the study.

About 12.8 percent of the sample were uninsured, close to the national average, Clancy said, and the trend is more, not fewer people losing their insurance.

PHOTOCOPY
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11. CONSTRUCTION/CARPENTRY ☐ Furniture Repair ☐ Locksmith Services ☐ Other					
12. DECORATOR SERVICES ☐ Select Furniture ☐ Touch-up ☐ Reupholstering ☐ Painting ☐ Carpet ☐ Other					
13. MOVING ☐ Furniture ☐ Safes ☐ Other (Attach copy of this form to EACH item being moved; Indicate specific description and destination of each item or group of items; A completed SF-120 MUST be attached to this form for all items being excessed)					
14. ELECTRICAL ☐ Outlet ☐ Cable ☐ Other					
15. TELEPHONE SERVICES ☐ New Lines ☐ Remove Lines ☐ Reconfiguration ☒ New Equipment ☐ Other lease telephone headset for merlin BIS 34					
16. CLEANING ☐ Carpet ☐ Furniture ☐ Drapery					
17. AGENCY AUTHORIZATION Janet M. Kelliher		18. DATE 9/24/93		19. FACILITIES AUTHORIZATION	
				20. DATE	

U.S. Government Messenger Envelope

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CAROL RASCO
Domestic Policy
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HILLARY RODHAM CLINTON
2ND FLOOR, WEST WING

Milli Alston
214 East 11th

TASK FORCE IN-TAKE
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Mike Lux

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Bob Bardskin
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Debra Streep
W JACKSON PC.

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THE PUBLIC HEALTH INITIATIVES

THE HEALTH SECURITY ACT OF 1993

THE HEALTH SECURITY ACT

The Health Security Act is more than a system to finance care for the sick. It changes the focus of the health care system toward:

- Improving the health of all Americans
- Reducing health disparities among Americans
- Containing accelerating health care costs

THE HEALTH SECURITY ACT OF 1993

PUBLIC HEALTH OBJECTIVES ACHIEVED BY:

- Restructuring the personal health care system
- Strengthening the public health system
- Improving the knowledge base/information systems

THE HEALTH SECURITY ACT OF 1993

KEY CHANGES IN THE PERSONAL HEALTH CARE SYSTEM

- Universal coverage
- Comprehensive benefits including clinical preventive services without cost-sharing
- Alliances and health plans responsible for providing their populations with access to covered services

THE HEALTH SECURITY ACT OF 1993

KEY CHANGES IN THE PERSONAL HEALTH CARE SYSTEM

- Report cards that focus attention of health plans on achieving healthy outcomes for their enrollees; monitor plan performance
- Financial incentives to keep populations healthy
 - Risk-adjusted per capita payments reward health plans for keeping their populations well
 - Healthier populations reduce alliance premiums

THE HEALTH SECURITY ACT OF 1993

STRENGTHENING PUBLIC HEALTH

Why?

- Public health system "in disarray" and a "threat to the health of the public"
 - Focus of public health agencies on providing personal medical care for the indigent has been at expense of keeping communities healthy
 - Less than 1% of health care expenditures goes to population-based public health activities

THE HEALTH SECURITY ACT OF 1993

STRENGTHENING PUBLIC HEALTH

- When public health fails, people suffer and health care costs increase
 - Every year, 900,000 fall ill--and 900 die--from drinking contaminated water; one recent outbreak affecting 370,000 people cost \$15 million.
 - Reductions in restaurant inspections contribute to outbreaks of Hepatitis A, which infected 75,000 Americans at a cost of \$766 million in 1987.
 - Failure to immunize high-risk for Hepatitis B results in 300,000 unnecessary cases per year, cost \$750 million.

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STRENGTHENING PUBLIC HEALTH

How? Through a new health oriented partnership that:

- Improves the capability of communities to prevent disease, improve health and address high priority local health problems
- Assures access to necessary health services for underserved populations through capacity expansion and enabling services
- Provides the knowledge base and information systems necessary to prevent disease more effectively and provide medical care more appropriately and efficiently

THE HEALTH SECURITY ACT OF 1993

IMPROVING PREVENTION AND PROTECTION CAPABILITY

- Strengthen essential public health functions at State and local levels
- Address priority health needs with community-based prevention programs

THE HEALTH SECURITY ACT OF 1993

CORE PUBLIC HEALTH PROGRAM

Competitive grants strengthen the ability of State and local public health agencies to:

- investigate and control community health problems
- protect communities from:
 - communicable diseases (TB)
 - environmental/occupational hazards (water)
 - preventable injury (helmets for bike accidents)
- educate the public about preventable health problems
- assure quality of medical and health services

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NATIONAL PREVENTION INITIATIVES PROGRAM

- Competitive grants help public and private not-for-profit agencies develop tailored, community-based interventions to address local health problems.
- Potential priorities could include:
 - prevention of smoking by children and youth
 - violence prevention
 - behavioral modification to prevent chronic diseases (cancer, heart disease, diabetes)

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ASSURING ACCESS TO CARE FOR THE UNDERSERVED

Health insurance DOESN'T GUARANTEE ACCESS to health care services

Currently, 72 million Americans live in inner-city and rural areas where there are insufficient numbers of providers or inadequate facilities. Culturally diverse or isolated populations confront other barriers to care.

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ACCESS INITIATIVES

The Health Security Act uses six interrelated approaches to assure that underserved populations not only have access to the full range of services included in the comprehensive benefits package, but also have an adequate choice of culturally sensitive providers and health plans.

These programs build on the existing network of safety net providers, giving them the resources they need to participate successfully in the new system.

1. Protect and strengthen current safety-net programs
2. Increase supply of practitioners in underserved areas
3. Expand capacity in inner-city and rural underserved areas
4. Provide additional outreach and enabling services
5. Expand mental health/substance abuse programs
6. Create two new programs directed at school-age youth

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CURRENT SAFETY-NET PROVIDERS

- Current programs such as community and migrant health centers, programs for the homeless, family planning, Ryan White, and maternal and child health will be maintained and strengthened.
- Providers funded under these programs will receive automatic designation as *essential community providers*:
 - guarantees payment for covered services from ALL health plans;
 - assures that vulnerable populations have continuing access to practitioners with experience meeting their special needs, regardless of which health plan they choose to enroll in.

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PRACTITIONER SUPPLY

- Expand the National Health Service Corps five fold from its current field strength of 1,600; target 20% of scholarships and loans to nurses
- Redirect residency training to substantially increase the ratio of primary care physicians to specialty physicians
- Support the training of primary care physicians, physician assistants and advance practice nurses
- Increase the number of minority health professionals

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CAPACITY EXPANSION

- Expand the community and migrant health center program
- Help groups of providers caring for underserved populations develop community practice networks and health plans.

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CAPACITY EXPANSION

- Grants and loans in the new program will be used to:
 - integrate publicly funded providers with other providers caring for underserved populations;
 - increase service availability in underserved areas by creating new practice sites and renovating existing sites, including public and rural hospitals; and
 - improve access to specialty care and coordination of care by linking providers in practice networks with each other and with regional and academic medical centers through information systems and telecommunications.

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OUTREACH/ENABLING SERVICES

- Establish a new competitive grant program to expand federal support for transportation, translation, child-care, and outreach services for public and private non-for-profit organizations experienced in caring for the underserved.
 - assures that isolated, culturally-diverse, hard-to-reach persons not served by other programs get the supplemental services they need to obtain access to medical care;
 - helps individuals and families who have been denied access to traditional medical care to shift their care patterns away from emergency rooms and receive earlier primary and preventive care.

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MENTAL HEALTH/SUBSTANCE ABUSE

- New funds will assure that low-income, hard-to-reach individuals know about and take advantage of the expanded mental health and substance abuse treatment benefits included in the comprehensive benefits package.
- The program will support community and patient outreach, transportation, translation, and education for vulnerable groups (homeless, dually-diagnosed, severely mentally ill);
- It will also improve the infrastructure for delivering mental health and substance abuse services in communities and for integrating these services within the broader health care system.

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SCHOOL-AGE YOUTH

Comprehensive School Health Education

- Establish a national framework within which States can create school health education programs
 - target grades K through 12 in areas with high needs
 - address locally-relevant health problems
 - reduce behavior patterns associated with preventable morbidity and mortality
- Provide waivers of existing programs to pool funds

THE HEALTH SECURITY ACT OF 1993

SCHOOL-AGE YOUTH School Health Related Services

- Provide grants to States or community partnerships to support the provision of health services in school-based or school-linked sites
- Target high-risk youth ages 10-19
- Include psychosocial services and counseling in disease prevention, health promotion, and individualized risk behavior

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ACCESS INITIATIVES

Why use a multifaceted approach?

- Under the Health Security Act, the challenge shifts from finding and funding providers to care for indigent, uninsured populations to creating a single tier system in which newly insured people have an adequate choice of culturally-sensitive providers and health plans.

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ACCESS INITIATIVES

- The flexible programs in the Access Initiative are designed to help diverse types of underserved communities:
 - attract the types of primary care practitioners and specialists that are currently in short supply in their areas;
 - offer their residents an array of practitioners and practice settings from which to receive health care services;
 - meet the enabling needs of diverse populations; and
 - link providers so as to assure the availability of the full range of services in the comprehensive benefits package.

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ACCESS INITIATIVES

How will the new programs affect federally-funded providers?

- The Health Security Act authorizes \$600 million in new funds for community and migrant health centers over fiscal years 1995 through 2000.
- A substantial portion of the resources from other programs will also benefit federally funded providers.
 - The new capacity expansion program (\$2.7 billion over FY 1995-2000) will provide funds that can be used to build new centers and clinics, to support capital improvements of

THE HEALTH SECURITY ACT OF 1993

existing centers and clinics, and to link federally funded providers with other providers and institutions through information systems and telecommunications.

-- Expansion of the National Health Service Corps (\$950 million over FY 1995-2000) and other workforce initiatives (\$820 million over FY 1995-2000) will increase the supply of practitioners from which centers and clinics in underserved areas can draw.

-- The new enabling services program (\$1.2 billion over FY 1996-2000) will provide federally funded providers with an additional source of funding to provide their populations with translation, transportation, child-care, and outreach services.

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-- The essential community provider designation program will assure federally funded providers payment for covered services from all health plans.

- Federally-funded providers will continue to get paid in full for all of their services, even if federal appropriations for Public Health Service programs decrease to account for increased revenues from health plans. The source of payment will change, however.

-- Payment for covered services will come from health plans instead of the federal government.

-- Payment for enabling services will come from the community and migrant health center program as well as

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the new enabling services program.

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IMPROVING THE KNOWLEDGE BASE & INFORMATION SYSTEMS

- Prevention research to learn how to promote health and prevent disease more effectively
- Health services research to treat the population more effectively and efficiently
- Improved information systems to help all participants in the system assess, improve, and make choices about care.

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PREVENTION RESEARCH

- Foundation for clinical preventive services and public health interventions
- Ensures availability of effective preventive measures against existing diseases and new/emerging health threats.
- Enables research to target populations that are disproportionately affected (eg. Alzheimer's disease, children's health, breast cancer, reproductive health).
- Preventing onset or progression of disease saves money -- delaying onset of Alzheimer's disease by 5 years would save \$90 billion annually

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HEALTH SERVICES RESEARCH

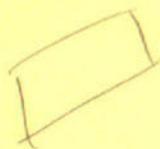
- Translate scientific advancements into the health delivery system to help control costs and improve the quality of life
- Identify what works best in medical care and how to provide care most efficiently and effectively.
- Develop practice guidelines to improve health care
- Develop accurate measures to assess the performance of alliances and health plans
- Identify how public health programs and personal health services can best be integrated

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Medicaid -

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Proctor
Wash

Home Care
314-889-6666

Hayes DDS
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816 5276
2829

TO : Dr. Risa Lavizzo-Mourey
FROM : Vicki Rivas-Vazquez
RE : Scheduled Television Interview
DATE : 10/12/93

Below is the information for television interview on **WEDNESDAY, OCTOBER 13TH**:

NEWS ORGANIZATION: C-Span *Fax 703 706-0002*
Contact: Ann Nicholas
(703) 706-3576
(202) 626-7964 (control room)

ISSUES : Health Care Plan - general questions

ANCHOR : Ann Nicholas

ARRIVAL TIME : 11:15am

INTERVIEW TIME : 11:30am - 12:30pm

FORMAT : 5-7 minutes - Katz general explanation
5-6 minutes - Robert Moffitt, Heritage Foundation - favors market competition, not in favor of Clinton plan; former HHS Deputy Asst Secretary under Reagan Administration, 50 minutes - Q/A from audience (40 senior citizens)

DURATION : 60 minutes

LOCATION : C-Span Studios
400 North Capitol Street
Suite 155

You should call Ann Nicholas for a pre-interview over the telephone. If you need any other information, please call me X2100. Thank you very much.

*Pat -
Please add this
to the list
that goes
down town*