NATIONAL CANCER INSTITUTE

Office of Cancer Communications

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National Institutes of Health

Press Release

FOR IMMEDIATE RELEASE

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Press Conference 9:30 a.m. EST

Thursday, November 14, 1996

NCI Press Office

(301) 496-6641

Cancer Death Rate Declined for the First Time Ever in the 1990s

The National Cancer Institute (NCI) announced today that the cancer death rate in the United States fell by nearly 3 percent between 1991 and 1995, the first sustained decline since national record-keeping was instituted in the 1930s.

The rates reported by NCI are based on mortality data collected by the National Center for Health Statistics of the Centers for Disease Control and Prevention. For 1995, preliminary data were used, so the precise numbers could change slightly once final data are available. But officials said they are confident that the trend is real.

"The recent drop in the cancer death rate marks a turning point from the steady increase we have seen throughout much of the century," said NCI Director Richard Klausner, M.D. "The 1990s will be remembered as the decade when we measurably turned the tide against cancer."

Klausner added that thousands of scientists, doctors, nurses, patients, volunteers, and others have devoted themselves to conquering this disease, and "this is the news we've been waiting for. We are on the eve of the 25th anniversary of the National Cancer Act, the legislation that made cancer research a high national priority. Now our nation's investment is paying off by saving lives. We are immensely gratified."

The overall cancer death rate is a composite of rates for many different types of cancer. The mortality trends for major cancers in men and women provide a more detailed picture of the relative success that has been achieved against each disease so far.

Most of the overall drop in the death rate is due to declines in lung, colorectal, and prostate cancer deaths in men, and breast, colorectal, and gynecologic cancer deaths in women. Some of these trends have been noted previously; for example the breast cancer death rate has been falling since 1989, and the colorectal cancer rates have been falling for about 10 years in men and several decades in women. Other trends, such as the decline in prostate cancer mortality, have only now become apparent.

"The decline in mortality reveals the strides we have made in prevention through tobacco control, in early detection, and in treatment," said Brenda K. Edwards, Ph.D., associate director for NCI's Cancer Control Research Program. "The knowledge that has flowed from years of research, combined with a massive

effort to apply that knowledge for the benefit of people, has made the difference."

The decline in mortality has been greater among men than women, although the absolute rate remains substantially higher in men. From 1991 to 1995 the rate declined 4.3 percent in men and 1.1 percent in women. By contrast, from 1971 to 1990, the rate rose 7.8 percent in men and 6.9 percent in women. The gender discrepancy in recent trends is largely a result of changes in lung cancer rates, which in turn are strongly influenced by smoking patterns. Lung cancer mortality fell 6.7 percent in men in the five-year period while rising 6.4 percent in women.

The decline in cancer mortality has been greater among African Americans than white Americans, although rates are still about 40 percent higher in black men than in white men. For blacks the overall rate declined 5.6 percent, while for whites the rate declined 1.7 percent. The decline in cancer mortality among blacks is largely due to trends in lung cancer in men and colorectal cancer in men and women.

The breast cancer death rate in women declined 6.3 percent between 1991 and 1995, with a larger decline in women under 65 (9.3 percent) compared with women 65 and older (2.8 percent). These gains reflect the success of both early detection and treatment advances.

Cervical cancer deaths fell 9.7 percent, reflecting the continued widespread use of Pap screening. Ovarian cancer deaths fell 4.8 percent, nearly all of the decline due to the trend in women under age 65.

Prostate cancer mortality declined 6.3 percent. The rate for men under age 75 fell 7.4 percent, while the rate for men 75 and older fell 3.8 percent. White men had a greater decline in prostate cancer mortality than black men. Causes of the prostate cancer trend are largely unclear, and additional time will be required to determine whether the decline continues.

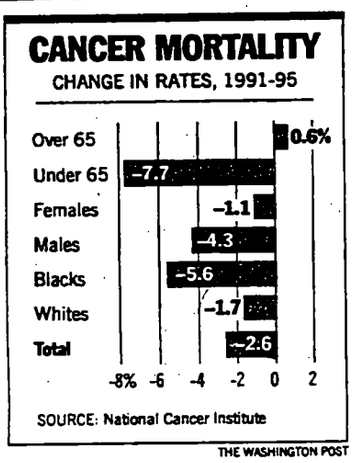
Colorectal cancer mortality continued to decline for both men and women, a trend that likely reflects the success of early detection, better treatment, and possibly changes in diet and other risk factors.

Mortality from non-Hodgkin's lymphoma continues to increase among both men and women. The causes of this lymphatic cancer are poorly understood and are under study.

NCI scientists plan to publish a detailed analysis of the trends in 1997.

For additional information, also see the Questions & Answers on Trends in Cancer Mortality in "Background" section of this site and Statement on the Decline in Cancer Mortality by Donna E. Shalala, Secretary of Health and Human Services in the "Press Release"section.

Statistical Charts Depicting the Drop in Cancer Mortality -- 11 charts visually depicting various aspects of the drop in cancer mortality.



Death Rates From Cancer Are Falling

Health Precautions, Early Detection Cited

By Curt Suplee
Washington Post Staff Writer

For the first time this century, cancer death rates have begun to decline steadily, according to two new studies, and the trend may be accelerating. As a result, leading experts predicted yesterday, mortality rates from all forms of cancer could decrease by 15 percent to 50 percent within the next 20 years.

The cancer mortality rate—the percentage of the U.S. population that dies from cancer each year—peaked at the beginning of this decade after increasing every year since the 1930s, when nationwide records were first collected systematically, researchers found. Beginning in 1991, the cancer mortality rate has dropped annually from a 1990 high of about 135 deaths a year per 100,000 people to 130.8 per 100,000 in 1995.

That does not necessarily mean that the total number of Americans dying of cancer will diminish in the near future. That is because the size of the U.S. population is increasing and the elderly—who are more prone to many cancers—make up an ever larger proportion of society. In addition, the incidence of cancer—the number of people being diagnosed with cancer—has continued to increase slightly, for reasons that are largely unknown.

Nonetheless, in the short term, the fall in the death rate means that at least 12,000 and possibly as many as 16,000 Americans will survive cancer this year who would have died if the rates were the same as they were in 1990, according to Harmon J. Eyre, chief medical officer of the American Cancer Society.

Experts attributed the dropping mortality rate in large part to the decrease in smoking, although a drop in drinking, exposure to the sun, and exposures to chemicals in the workplace also played a role. In addition, improved early detection methods and new medical treatments have improved cancer survival rates, they said.

"We see this as a real triumph in a long and incredibly intense struggle to reduce the burden of cancer," said National Cancer Institute Director Richard D. Klausner.

The new findings arise from two independent but complementary studies by academic researchers and NCI staff.

Philip Cole and Brad Rodu of the University of Alabama at Birmingham, whose analysis is being published in Friday's issue of the ACS journal Cancer, conclude that total mortality rates from all forms of cancer hit a plateau in 1990, and fell by about 3.1 percent from 1990 to 1995. That means a drop in death rates of about 4.2 cases per hundred

See CANCER, A4, Col. 1

CANCER, From A1

thousand person-years—about 40 percent of which, they determined, is attributable to decreases in lung cancer fatality.

Cole and Rodu based their conclusions on examination of three nationwide data sets: the federal government's Vital Statistics of the United States; the Center for Disease Control and Prevention's monthly mortality reports; and fatality information from NCI's broad-based national surveillance program.

While Cole and Rodu were preparing their report, NCI researchers involved in a separate review of national cancer fatality figures were coming to a similar conclusion. NCI's final report is due in 1997. But in a summary released yesterday, NCI stated that it, too, had discerned an approximately 3 percent drop in death rates from 1990 to 1995.

Most of it, the summary said, "is due to declines in lung, colorectal and prostate cancer deaths in men, and breast, colorectal and gynecologic cancer deaths in women."

Statistically, African Americans benefited most from the mortality-rate improvements, NCI found. From 1991 to 1995, the overall cancer death rate among white Americans dropped by 1.7 percent. But the mortality rate for all cancer sites combined declined 5.6 percent among blacks, in sharp contrast to an 18.3 percent rise in the rate between 1971 and 1990, the NCI found. Much of that reduction "is due to a 10 percent decline in lung cancer deaths among black men, which account for one-third of all cancer deaths in black men," the NCI stated.

The NCI researchers noted that the death rate for certain cancers and certain groups have continued to increase despite the overall decline. In men, mortality from lymphatic cancers has risen, for example; so have lung cancer deaths in women aged 65 and older.

Representatives of the ACS, NCI and CDC have scheduled a joint news conference for 9:30 this morning at the National Press Club to announce the findings and to call for more aggressive coordination among government, the private sector and volunteer groups.

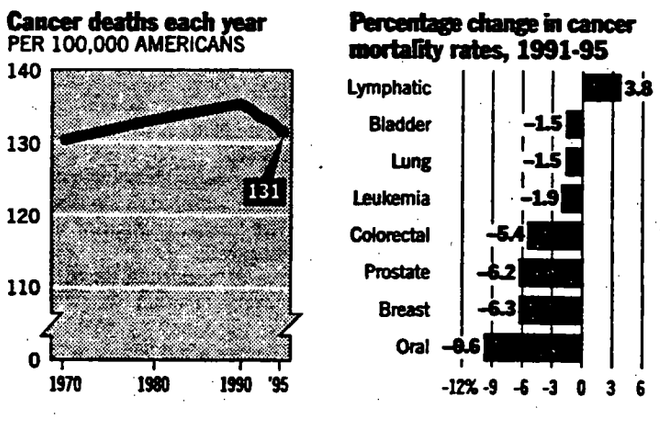
Eyre of the ACS said that skeptics have downplayed the significance of the results, arguing that a decline in mortality rate of 0.5 percent to 2 percent per year is "pretty small" and that people who escape death by cancer will, inevitably, die of something else. Those views, he said, are misleading.

"There will always be a leading cause of death. The question is: At what age do people die, and how much premature life is lost due to the disease?" Unlike heart attacks and stroke, which tend to occur late in life, "cancer arises at different stages of life, affecting more people in their forties and fifties than cardiovascular disease and so accounts for more years of life lost," he said.

So "when cancer as a group of diseases is eliminated, the population will live longer with a better quality of life."

TRACKING THE TREND

Two separate studies show a steady decline in the mortality rate from cancer for the first time in U.S. history. Experts expect the trend to continue.



The Washington Post
THURSDAY, NOVEMBER 14, 1996

The Washington Post
THURSDAY, NOVEMBER 14, 1996

2/2

INTERNATIONAL FORCE TO THE RESCUE

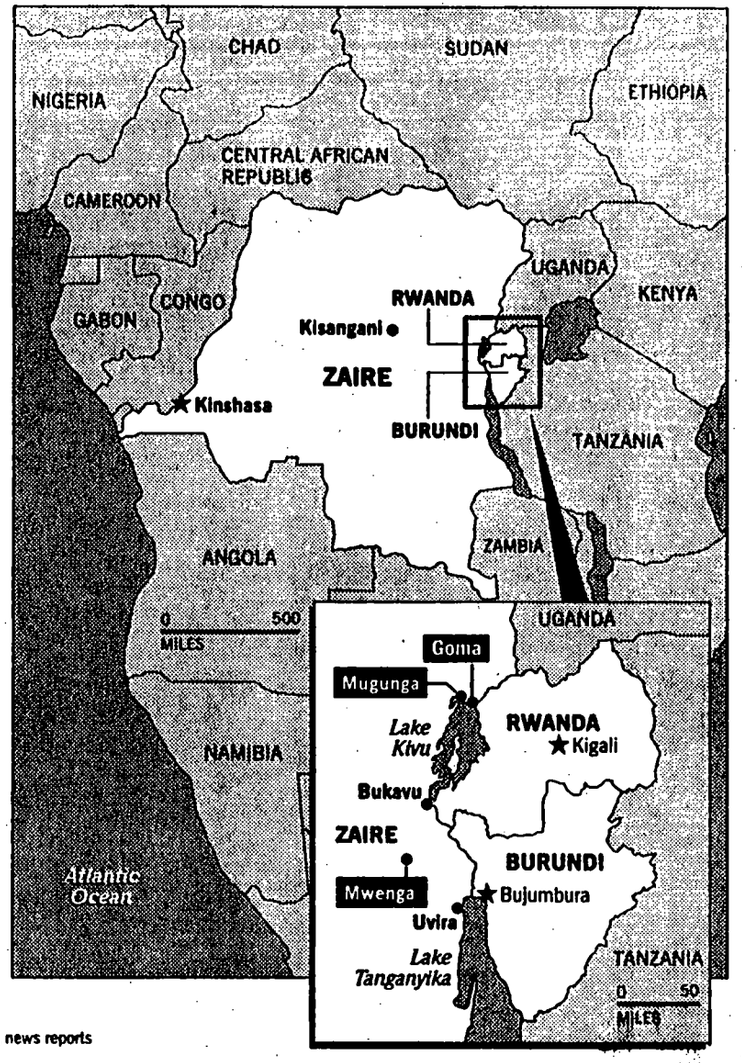
A Canadian-led international force of more than 15,000 troops, including Americans, may go to Zaire soon to secure operations by aid organizations that are trying to feed Hutu refugees and help them return to Rwanda.

TROUBLE SPOTS

Goma: A city of 80,000 now controlled by Zairian Tutsi rebels who captured it as well as Bukavu and Uvira two weeks ago. The international force may fly into Goma airport and secure a road leading to the Rwandan border, to open a corridor for the safe return of refugees.

Mugunga, the remaining refugee camp in Zaire, has become the center of Hutu militants. About 500,000 Hutu refugees are now concentrated there, including many who fled camps farther south. Another 300,000 refugees, who fled other camps, are stranded without aid along a road about six miles south of Mugunga.

Mwenga: About 250,000 refugees are stranded near this town after fleeing fighting that began three weeks ago. Other refugees who fled the clashes are wandering the roads and countryside of Zaire; some have reached Uganda.



SOURCES: The International Institute of Strategic Studies, news reports

ZAIRIAN ARMY

Poorly trained, ill-equipped and often unpaid, Zaire's 49,000-man regular army has largely had to go its own way in recent years. In the absence of support from the central government in Kinshasa, soldiers have relied on shakedowns and occasional looting to support themselves, particularly in the east. A separate force, Zairian leader Mobutu Sese Seko's Presidential Guard, is better disciplined but is loyal only to Mobutu, who is in Europe recovering from cancer surgery.

RWANDAN ARMY

Until July 1994, the present Rwandan army was a Tutsi-led rebel force, the Rwandan Patriotic Army, based in Uganda. Following the 1994 massacres of Tutsis and moderate Hutus by a militant Hutu Rwandan government, the rebels routed Rwanda's Hutu army and militias and installed a new government. Battle-hardened and relatively well equipped, the force, estimated at 40,000 troops, is led by Maj. Gen. Paul Kagame, who was trained in the United States and is considered a skilled tactician. The army has been plagued, however, by guerrilla attacks by Hutu refugees in Zaire and accused of reprisal killings following the 1994 genocide.

ZAIRIAN REBELS

The rebel force that has been fighting Zairian army troops since at least September—and is now battling armed Hutu refugees—appears to be primarily composed of ethnic Tutsis. Tutsis have been in what is now eastern Zaire since the 18th century. In 1981, Zaire revoked their citizenship rights, and the Tutsis have since taken up arms against the central government. The rebels' leaders say their movement also embraces members of other ethnic groups and from other regions, seeking to overthrow Zairian leader Mobutu Sese Seko. But the force's battlefield success, along with the fact that its attacks have cleared out Rwandan Hutu refugee camps, have led to accusations by Zaire that the rebels are backed by the Tutsi-led government of Rwanda, and possibly by Burundi as well.

HUTU REFUGEES

An estimated 1.1 million Rwandan Hutus fled to Zaire after the Rwandan Patriotic Army ousted the Hutu-led Rwandan government that carried out the 1994 genocide. They set up about 40 camps near Goma and along the Rwandan and Burundi borders. The camps have served as havens for former political and military leaders who orchestrated the genocide, and they have staged sporadic guerrilla raids against the Rwandan government.

To: Pauline Abernathy
Fax #: 202-456-2878
Re: Hospital Profitability
Date: November 26, 1996
Pages: 7, including this cover sheet.

FACSIMILE

Here is what our staff have been able to come up with so far. We are still checking with some other sources and will let you know if we come up with any thing more.

ProPAC estimates ** aggregate Medicare inpatient PPS margins ** to reach 8% in 1996 PPS fiscal year, the highest since 1986. They estimate roughly 5.5 for 1995. (Guterman et al., Health Affairs, Fall 1996). [attached] It is a remarkable bounce back from the negative PPS margins of 1990 - 92, which appear to be achieved by cost reductions by hospitals.

They use early evidence from Medicare Cost Reports, their own trending models, plus communications from AHA about continuing trend of hospital costs as of Dec 95.

- The Aggregate is sometimes a far cry from the median. The Aggregate essentially weights large hospitals more. ProPAC report of June 96 gives PPS inpatient margin estimate for FY94 (PPS-11) breakdown:

Medians:

> All hospitals 1.2% (it had been negative for 5 previous fiscal years)
> Large Urban 4.2
> Other Urban 0.3
> Rural referral 1.3
> Sole community 4.3
> Other rural -2.1

- Total margins (all products to all payers) are much more stable over time than Medicare inpatient PPS margins. They are estimated by ProPAC at 4.7% in 1994 and have been between 3 and 5 for two decades with a wee bit more in 85-86. Our research for the decade of the 1980's found that most explainable variation was "between" hospitals, with some temporary short-term variations in years of "windfalls" or unusual stress.
- Median total margin did not vary much by rural/urban status: Large Urban 3.4, Other rural 3.2

Three notes:

(1) Since depreciation is based on historical cost, and new investment can be slow to generate full revenue potential -- BEWARE: if a hospital stops building/modernizing/investing/growing, you could see misleading lower costs and higher profit in the shortrun. Of course, if you think that we have excess capacity, it's great that hospitals would "eat up capital" and we should ratchet down the payments.

From the desk of...

Lisa Simpson, MB, BCH, MPH
Deputy Administrator
Agency for Health Care Policy and Research
2101 East Jefferson St.
Rockville, MD 20852

301-594-6662
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(2) Hospital profitability, unlike for other enterprises, is measured as percent of revenue rather than return on "equity". This requires cautions in an era of major reorganizations. Operations that yield costs and revenues can be spun off to other legal entities and joint ventures of the parent organization, leaving unknown effects on what remains in the "hospital" per se.
(3) Related to points (1 and 2) hospitals responded to slowing inpatient demand with very large investment and ventures for outpatient services. These were the engine of growth for many hospitals, and subject to FFS billing. That is clearly slowing -- but perhaps it is being split off as well?

Please do not hesitate to call if you have any questions.

Lisa Simpson MB, BCH
Deputy Administrator

Hospital Cost Growth Down

Unprecedented cost constraint by hospitals has maintained their bottom line. But can it continue?

BY STUART GUTERMAN, JACK ASHBY, AND TIMOTHY GREENE

HOSPITALS OPERATE IN A rapidly changing health care environment. They have faced increasing pressure from payers to lower prices for their services and more competition from other health care providers. Hospitals have responded to these pressures with unprecedented cost constraint. They have, in fact, improved their fiscal condition.

Here we review hospital cost trends of the past decade or so to understand better the pattern of cost growth, its relationship to hospitals' financial status, and some of the factors that underlie these trends. We pay particular attention to cost shifting—the dynamic interaction among payment flows from various payers. How this interaction unfolds has important implications for health policy.[1]

TRENDS IN HOSPITAL COSTS

Medicare implemented the hospital prospective payment system (PPS) in fiscal year 1984.[2] Hospitals anticipated that under the new system they would face pressure to keep their costs below the fixed per case payment rate. Consequently, inpatient operating costs per case increased only 1.8 percent in the first year of PPS (Exhibit 1).[3]

The anticipated pressure, however, did not materialize. In fact, PPS operating payments per case rose by 18.5 percent in the first year and 10.5 percent in the second. This is attributable to two factors: (1) The base-year hospital costs upon which the initial PPS rates were set were overestimated because of the use of unaudited Medicare Cost Reports; and (2) the Medicare case-mix index, which represents the costliness of cases treated by each hospital and determines the level of payments, increased by more than expected because of greater emphasis on coding and documentation of the medical record.

In the second through the seventh years hospitals returned to the rapid cost growth that prevailed before PPS. The increase in operating costs per case averaged 9.4 percent—much more than operating payments per case rose over the same period. By 1990 cumulative cost growth had exceeded combined payment increases.

There has been a marked change in the cost trend since 1990. Not only did the aggregate level of PPS costs exceed PPS payments for the first time in that year, but other changes in health care markets were increasing the financial pressure on hospitals as well. Operating costs per case grew only 6.9 percent in 1991—the smallest rise since the first year of PPS. Costs rose 1.3 percent per case in 1993 (below general inflation) and actually decreased by 1.3 percent in 1994. Available information indicates that hospitals continued to constrain their cost growth through 1995.[4]

FINANCIAL CONDITION

■ **PPS INPATIENT MARGINS.** The PPS inpatient margin compares combined Medicare operating and capital payments with the corresponding costs.[5] In 1994 the aggregate PPS margin rose for the third consecutive year to 4.7 percent (Exhibit 2). This contrasts with a declining trend through the first eight years of prospective payment, during which the margin fell to a low of −2.5 percent. The turn-

Stuart Guterman is deputy director of the Prospective Payment Assessment Commission (ProPAC) in Washington, D.C. Jack Ashby and Timothy Greene are senior health policy analysts there.

EXHIBIT 1
Annual Change Per Case, First

SOURCE: ProPAC an
NOTES: Data for eac
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EXHIBIT 2
Aggregate Pr
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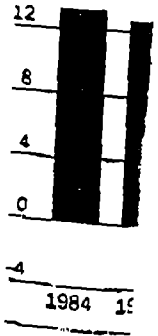

SOURCE: ProPAC
NOTES: Data for
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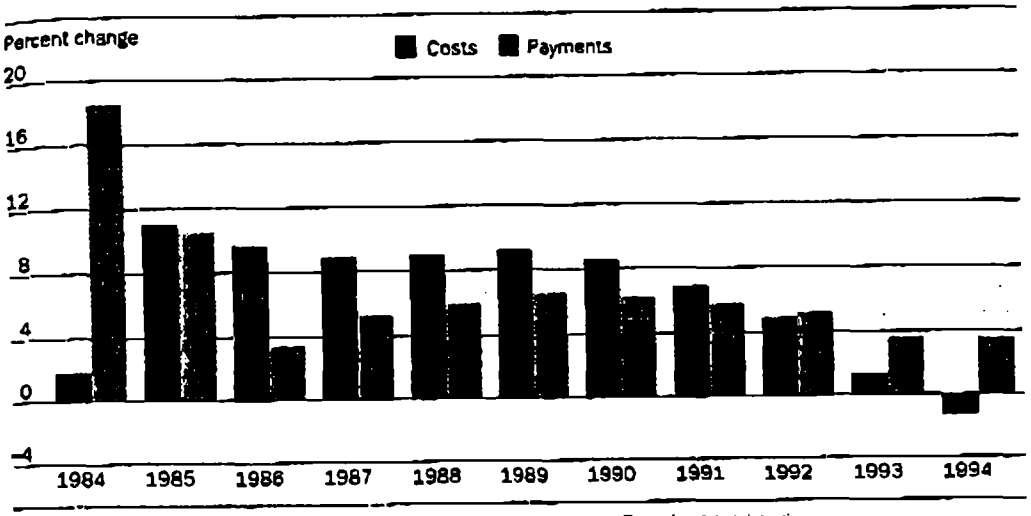
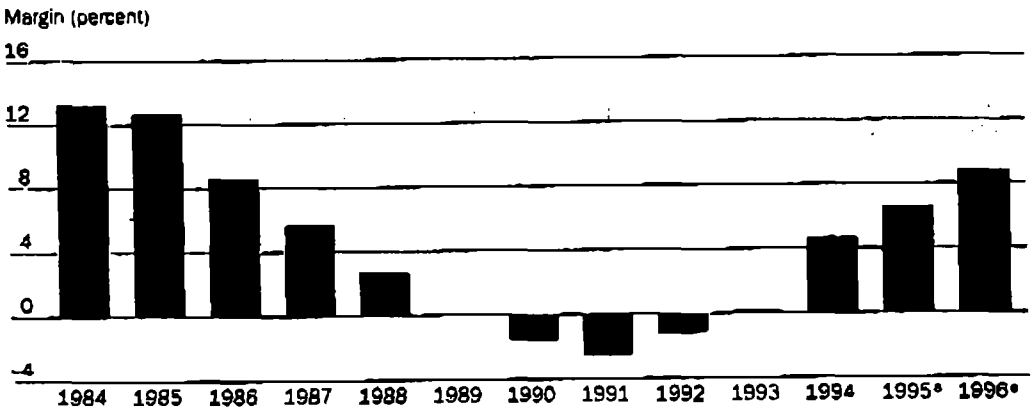
EXHIBIT 1
Annual Change In Prospective Payment System (PPS) Operating Costs And Payments Per Case, First Eleven Years Of PPS



SOURCE: ProPAC analysis of Medicare Cost Report data from the Health Care Financing Administration.
NOTES: Data for each year are from hospital cost reports for periods beginning during the corresponding federal fiscal year, excluding hospitals that were not paid under PPS during that year. Changes are based on cohorts of hospitals with cost reports in each of two consecutive years.

EXHIBIT 2
Aggregate Prospective Payment System (PPS) Inpatient Margin, First Thirteen Years Of PPS



SOURCE: ProPAC analysis of Medicare Cost Report data from the Health Care Financing Administration.
NOTES: Data for each PPS year are from hospital cost reports for periods beginning during the corresponding federal fiscal year, excluding hospitals that were not paid under PPS during that year.
[a] Margin estimated for 1995 and 1996, based on currently available data on cost and payment trends.

around is attributable to the sharp slowdown in hospital cost growth. If current trends continue, the aggregate PPS inpatient margin for 1996 will rise to 8.8 percent.[6]

■ TOTAL HOSPITAL MARGINS. How hospitals respond to changes in Medicare payment policies is determined by their overall payment and cost environment. Throughout the years since the implementation of PPS, total hospital revenues and expenses have tracked remarkably closely. From 1985 through 1992, while total expenses per case rose between 7.8 percent and 9.3 percent, total revenues per case increased between 7.7 percent and 9.4 percent.[7] This indicates that despite the rapid growth in costs during this period, hospitals were able to generate the overall income necessary to cover their costs. In fact, from 1981 to 1992 cost increases exceeded revenue increases in only three of the twelve years—1986, 1987, and 1988.

"Although the pattern changed in the early 1990s, cost shifting continues to be an important factor."

More recently, the flow of funds to hospitals has been more limited. Total hospital revenues per case grew by only 5.4 percent in 1993, or 2.4 percent above general inflation—the smallest real increase in more than a decade. Hospitals responded to this pressure by reducing growth in total expenses per case to 5.8 percent. There was even more pressure from payers on prices of hospital services in 1994, as revenues per case declined in real terms. Again, hospitals responded by curtailing costs, with a 1.6 percent increase in expenses per case—well below general inflation and 0.6 percentage points lower than the increase in revenues.[8]

The total margin indicates the extent to which hospitals produce enough revenues to cover their expenses (or their success in holding costs below payments).[9] Because it reflects revenues and expenses from all sources (including activities other than patient care), the total margin is the best available measure of overall hospital financial status. Revenue growth through the 1970s and early 1980s resulted in rising total margins. As shown in Exhibit 3, the early years of PPS saw a large increase in the aggregate total margin, partly because of high profits on Medicare cases. In subsequent years—as Medicare tightened its control over inpatient payment rate increases—the total margin began to fall. In the late 1980s, however, the total margin bottomed out at 3.3 percent, and by 1991 it had risen to 4.3 percent. The total margin remained steady through 1993 and then increased to 4.8 percent in 1994, the highest level since 1986 and above the levels experienced before PPS began.

ROLE OF COST SHIFTING

Cost shifting occurs when hospitals use revenue gains from certain payers to offset other revenue shortfalls. Hospitals have long received higher payments relative to costs from some payers than from others, and surplus funds from at least some private insurers have always been the primary method of financing bad debts and charity care. But *cost shifting* refers to the relationship between changes in the prices paid by different groups; that is, an increase in losses (or a decrease in gains) from one source creates pressure to generate an offsetting increase in revenue from another source.[10]

The trends in payments and costs through the 1980s provide strong evidence that this relationship exists. Moreover, although the pattern changed in the early 1990s, cost shifting continues to be an important factor when considering the implications of potential policy changes.

In the latter half of the 1980s and the early 1990s, as discussed earlier, Medicare payments rose much more slowly than did the costs of treating Medicare patients. Total Medicare payments to hospitals for inpatient, outpatient, and postacute care, which had exceeded the corresponding costs in 1985 and

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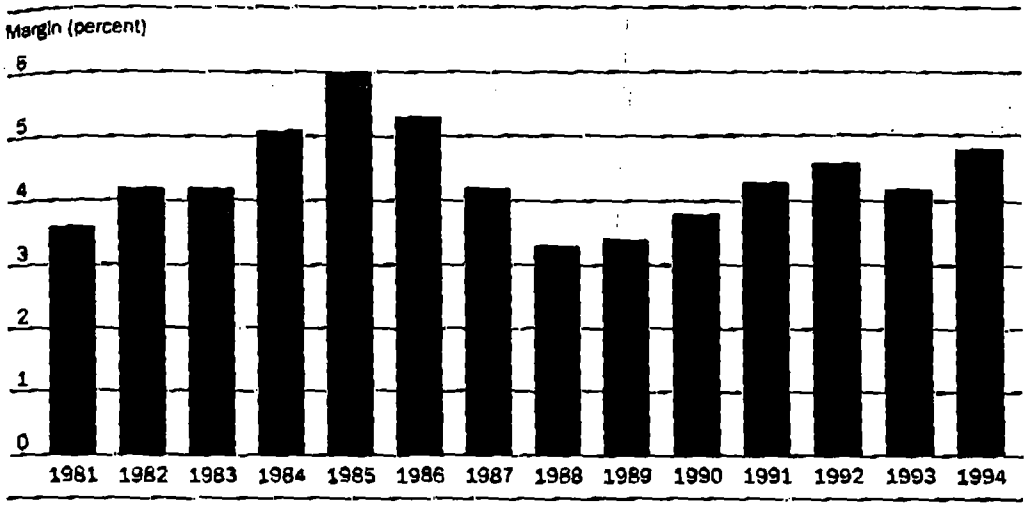
EXHIBIT 3
Aggregate Total Margin, 1981–1994



SOURCE: American Hospital Association Annual Survey of Hospitals.

EXHIBIT 4
Hospital Payment-To-Cost Ratios, By Payer, 1980–1994

Year	Medicare	Medicaid	Private payer
1980	0.96	0.91	1.12
1981	0.97	0.93	1.12
1982	0.96	0.91	1.14
1983	0.97	0.92	1.16
1984	0.98	0.88	1.16
1985	1.01	0.90	1.16
1986	1.01	0.88	1.16
1987	0.98	0.83	1.20
1988	0.94	0.80	1.22
1989	0.91	0.76	1.22
1990	0.89	0.80	1.27
1991	0.88	0.82	1.30
1992	0.89	0.91	1.31
1993	0.89	0.93	1.29
1994	0.97	0.94	1.24

SOURCE: ProPAC analysis of data from the American Hospital Association Annual Survey of Hospitals.
NOTES: Payments and costs include both inpatient and outpatient services in acute care and other hospital units. Most revenues and costs from Medicare risk plans and Medicaid health maintenance organizations (HMOs) are included in the private payer category. Because of reporting inconsistencies related to Medicaid disproportionate-share payments and provider-specific taxes, there is some bias in the payment-to-cost ratios for all payers since about 1991. This, however, should not affect the qualitative interpretation of the data.

1986, fell to 88 percent of costs by 1991 (Exhibit 4).[11] Although uncompensated care losses were relatively constant, Medicaid payments also fell relative to costs. However, hospitals generally were able to cover their higher losses by shifting costs to private insurers. Between 1986 and 1991 the ratio of private-payer payments to costs rose from 116 percent to 130 percent. This was how hospitals were able to maintain their fairly stable total margins.[12]

In recent years more private insurers have been actively constraining their payments to hospitals. The private-payer payment-to-cost ratio reached a peak of 131 percent in 1992 and then fell to 124 percent in 1994. Meanwhile, Medicare payments have increased as slowly as at any time since the implementation of PPS. Medicaid payments, which rose steeply in 1992 with an infusion of funds from the federal government to support growing state payments to disproportionate-share hospitals, have been more constrained since then.[13]

Lacking a ready source of additional revenue, hospitals have responded by sharply reducing their cost growth. Ironically, because of this lower cost inflation, the Medicare payment-to-cost ratio has increased substantially, to 97 percent in 1994.[14] For some hospitals, improved Medicare margins may be cushioning the impact of the changes among private payers.

Conclusions

In a rapidly changing health care environment, hospitals have maintained—and in some cases, even improved—their financial status. This has been accomplished through reductions in cost growth that are unprecedented in their magnitude and duration.

Payments from private payers as a percentage of patient care costs fell for the first time in 1993, and this trend accelerated in 1994. Hospitals, no longer able to generate the revenue necessary to cover the rapid cost growth seen in the 1980s, responded by sharply constraining their spending. However, all hospitals do not feel the implications of this change equally. Many hospitals still receive large enough surpluses from private payers to maintain their total margins. Others receive enough additional indirect medical education or disproportionate-share payments from Medicare or Medicaid to protect their financial status. Some hospitals, though, do not have a large enough share of privately insured patients, or enough payment leverage with private payers, to offset their losses from charity care and bad debts.

Because of diminished cost growth, PPS inpatient margins are rebounding from their negative levels of several years ago. The wide fluctuations in the PPS margin are primarily attributable to the trend in costs, not payments. Medicare payments per case for inpatient hospital services have been fairly stable over time, and the increases in recent years have been among the lowest since the implementation of PPS.

As Medicare payment policy is deliberated in the coming months and years, decision-makers will have to balance some important considerations. PPS updates historically have been pegged to a reasonable rate of increase in the cost of providing inpatient care to Medicare beneficiaries. This has led to stable increases in payments per case, despite tremendous pressure to raise payments in the face of negative margins and to lower them when margins are high.

At the same time, Medicare, as a public payer, has a responsibility to be a prudent purchaser of health care, and the projected insolvency of the Hospital Insurance (HI) Trust Fund magnifies the importance of that role. Taking advantage of the forces at play in the private sector could result in substantial savings for the program.

As the recent health care reform debate has shown, striking a balance between these two roles is difficult. Sharp reductions in Medicare payment rates could compromise access to and quality of care for beneficiaries. On the other hand, setting rates at levels that are inconsistent with current market conditions could result in excess program spending that increases the threat of Medicare insolvency and hinders attempts to reduce the federal budget deficit. The solution must take into

account the needs of Medicare beneficiaries, the fiscal stability of the program, and the impact on government spending, keeping in mind the broader influence Medicare has on the financing and provision of health care in this country.

NOTES

1. See Prospective Payment Assessment Commission, *Medicare and the American Health Care System* (Washington: ProPAC, June 1996).
2. Initially, PPS applied only to inpatient operating costs, which include all Medicare-allowable routine and ancillary (but not capital) costs. PPS for inpatient capital costs took effect in FY 1992.
3. The degree of each hospital's cost response to PPS was related to the severity of anticipated pressure. See J. Feder, J. Hadley, and S. Zuckerman, "How Did Medicare PPS Affect Hospitals?" *The New England Journal of Medicine* 317, no. 14 (1987): 862–873.
4. American Hospital Association, National Hospital Panel Survey, December 1995.
5. The PPS inpatient margin is computed as [PPS inpatient payments–PPS inpatient costs]/[PPS inpatient payments]. The aggregate PPS inpatient margin is computed by summing PPS inpatient (operating plus capital) payments and costs for all hospitals.
6. The latest available data on PPS inpatient margins are from the Medicare Cost Reports filed by each hospital for the cost reporting period beginning during federal FY 1994. PPS inpatient margins for 1995 and 1996 were estimated by applying information on current payment and cost trends to that base. The payment trend is estimated using the FY 1995 and 1996 updates to the PPS operating and capital payment rates and ProPAC estimates of the increase in the PPS case-mix index. The cost trend is estimated using monthly data through December 1995 on total hospital expenses per adjusted admission from the AHA's National Hospital Panel Survey.
7. Data on total revenues and expenses per adjusted admission are from the AHA Annual Survey of Hospitals. Total revenues and expenses include all sources, including inpatient and outpatient acute care and postacute care based in the hospital, as well as hospital activities unrelated to patient care, such as parking, catering, and gift shop services. Adjusted admissions are a measure of the combined volume of inpatient and outpatient services provided by a hospital.
8. The cost growth figures cited here differ somewhat from those presented earlier. The earlier data describe the trend in Medicare inpatient operating costs per case, whereas these portray total hospital expenses per adjusted admission. This measure includes not only Medicare inpatient operating costs, but also Medicare inpatient capital and outpatient costs, inpatient and outpatient costs for other patients, and nonpatient care costs incurred by the hospital.
9. The total margin is computed as [total hospital revenues–total hospital expenses]/[total hospital revenues]. The aggregate total margin is computed by summing total hospital revenues and expenses for all hospitals.
10. See ProPAC, *The Relationship of Hospital Costs and Payment by Source of Revenue, 1980–1991*, Intramural Report 1-95-01 (Washington: ProPAC, October 1995).
11. The payment-to-cost ratio for each payer category is computed using the charges and payments by category reported by each hospital in the AHA Annual Survey of Hospitals. A hospital-level ratio of expenses to charges is then applied to the reported charges by category to derive an estimate of costs by category for each hospital. Payments and costs by category are aggregated for all hospitals, and the ratio of payments to costs is computed for each category. Values are imputed for hospitals that do not provide the data necessary to compute the relevant variables. This may affect the payment-to-cost ratios for each payer in each year but is unlikely to distort the patterns across payers or years.
12. Because Medicare and private payers account for similar shares of total hospital costs, a decrease in the ratio of payments to costs from one source can be offset by an about equal increase in the ratio from the other source.
13. The increased federal funding of Medicaid disproportionate-share payments came through the use of provider-specific taxes and donations to the state Medicaid programs, which since have been limited by federal law. See ProPAC, *Analysis of Medicaid Disproportionate Share Payment Adjustments*, Congressional Report C-94-01 (Washington: ProPAC, 1 January 1994).
14. The 97 percent Medicare payment-to-cost ratio in 1994 contrasts with the PPS margin of 4.7 percent in the same year. This is attributable to the broader scope of the payment-to-cost ratio, which reflects payments and costs for all Medicare services (inpatient and outpatient acute care, medical education programs, and hospital-based postacute care). Payments for outpatient services, medical education, and post- acute care tend to be below reported costs because of the use of fee schedules, discounts from cost-based rates, and payment limits. In addition, the payment-to-cost ratio reflects Medicare's share of all hospital costs, whereas the PPS margin is calculated using only Medicare-allowable costs, which are believed to be 3–5 percent lower.

December 18, 1996

TO: Chris Jennings ✓
Lissa Muscatine

FROM: HRC

clippings for health care speech

Pauline,
FYI

Observer

RUSSELL BAKER

Harry! Louise! You Lied

They told us that national health care would deprive us of the right to choose our own doctors.

So we said no to national health care.

And we found ourselves enrolled in something called an H.M.O. It gave you a list of doctors to choose from. If your doctor wasn't listed, they told you to forget him.

They told you to choose one of the doctors on the H.M.O.'s list, or else. "Or else" meant your health insurance wouldn't pay your doctor's bill.

They had deprived us of the right to choose our own doctors.

And they told us if we had national health care there would be Government bureaucrats interfering with our medical treatment.

Strangling us with red tape.

Burying us under tons of paperwork.

So we said no to national health care.

We said yes to the great insurance corporations of America, and perhaps of the entire planet now that conglomerated capital no longer recognizes national boundaries.

We said yes because we did not want Government bureaucrats interfering with our medical treatment.

Did not want to be strangled with red tape.

Didn't want to be buried under tons of paper.

So we said no to national health care and said yes to great-insurance-company health care.

And we found ourselves up to the neck bone in bureaucrats.

Not Government bureaucrats, to be sure.

That's right: The bureaucrats who occupied more and more of our lives were not Government bureaucrats. They were great-insurance-company-of-America-and-possibly-the-whole-darn-world bureaucrats.

In bureaucrats we were up to the neck bone.

The neck bone is the seat not only of the infamous pain in the neck, but also of three-day headaches, sour stomach, criminal dreams of blowing up the great insurance corporations of America, and hatred for our fellow man, though more often our fellow woman since the bureaucrats most often encountered in the typical soul-crushing struggle with a great insurance corporation of America seem to be female.

Whenever such a bureaucrat can be reached by telephone live.

By those with sufficient patience to press numbers 1 through 117 in search of a human voice.

And what was that red material so tightly wrapped around our necks? It was tape. Dreadful, terrifying red tape. But not the Government's red tape.

It was the red tape of great insurance companies, of H.M.O.'s, of various and sundry doctors and the squadrons of accountants who managed their vast files of paper.

Affidavits, certified X-rays, notarized doctors' statements, histories of previous ailments, professionally attested-to prospectuses of sicknesses likely to be incurred in futures both near and far, sworn evidence of abstinence from cigarettes, solemn oaths not to develop long-term diseases, F.B.I. records if available on

> Up to the neck in bureaucrats.

drinking habits and sexual proclivities in your youth, any and all records forecasting genetic tendencies to ill health, criminal activity, out-of-body adventuring and susceptibility to kidnaping by aliens conducting experiments on humans in U.F.O.'s. Such was but a small sampling of the privately contrived nongovernmental red tape that strangled us.

Paper! How thick it rose around us, how densely it filled the air. That's why we felt buried under a stifling, crushing tonnage: paper! We had said no to national health care to avoid being buried under tons of paper. And here we were. Buried.

Under tons of paper.

They told us that national health care would cost us billions in taxes. Leave it to the free market, they said, and it wouldn't cost us a cent to continue enjoying the best medicine in the world.

Provided we had private health insurance.

So we said no to national health care. We did not want to pay zillions in taxes. We did not even want to pay $1.79 in taxes, to be perfectly frank. Especially since we had health insurance, all but 30 or 40 million of us. We said the great free market should be allowed to do its work.

And that was the end of national health care. The health industry is cleaning up on Wall Street. The rest of us pray we may never get sick. □

Losing control

Can we save our health-care system?

Joan Beck

Perhaps because they hadn't rehearsed it, both President Clinton and Bob Dole flubbed the same question in Wednesday's presidential debate.

But unless the next president can find an answer, the issue will cost many Americans their health—and some their lives.

Verda Strategus, a health-care worker in the audience, told the candidates, "Managed care is taking over, especially in California. And because of that, the quality of care is going downhill. There are many, many people who cannot get the tests that they need, when they need them. And because of that, they are dying needlessly.

"There are many, many more lawsuits being presented against the managed-care industry because of this. What would you do if you were president?"

Neither candidate had a good answer. Both men stumbled around trying to fill the assigned time with empty verbiage. Dole responded by recycling old sound bites about the failed Clinton health plan and suggested the president might try again to get it passed if re-elected. Dole did concede that we will have to watch what's happening or "we're going to end up losing our best care that we have in the world." Clinton ran the clock down by asking the audience how many are in a managed-care plan (a majority raised their hands) and how many of them like it (only two). He did say he favored a federal bill to repeal gag rules on providers that prevent physicians from telling patients they need a more expensive test or treatment.

When time was up, the question hung unanswered in the politicized air, sure to haunt whoever wins the White House and whoever is elected to Congress.

American health care is in great jeopardy, as rapid changes push millions of people into managed care—like it or not, tested or not. By 1995, more than 149 million Americans belonged to HMOs or preferred-provider organizations.

The unhealthy side effects of a for-profit system are becoming increasingly clear, as the welfare of stockholders and highly paid executives takes precedence over the health of patients.

Money is being wrung out of health care, as managed-care organizations promised. But it is not being spent to improve medical facilities or for research or better treatment. Much of it is being used to put health care into play on Wall Street, where patients are being traded, sold, merged and brokered for profit like so many pork bellies.

To wring costs down, managed-care organizations and health insurers are cutting payments to hospitals to the worrisome point. Hospitals are being forced to reduce nursing staffs, rely on semi-skilled aides and drastically limit stays. Many may have to close, downsize, go bankrupt or merge, especially those which care for many uninsured people.

Medical specialists are being devalued. Many HMOs limit patients' access to physicians other than their primary care "gatekeeper" except in compelling circumstances. Some plans even penalize a doctor financially for letting a patient see a specialist. As money dries up, fewer doctors may be trained as specialists in the future—even as medicine grows more complex and difficult.

Patients may fare well when all they need are a pap smear, immunizations for their children and help for an occasional sprained ankle. In any given year, 85 percent of insured people don't go to a doctor; the HMO makes money on them.

But as yet, managed-care organizations don't have a clear or reassuring track record on caring for those who are seriously, chronically or expensively ill and where financial pressures to reduce care are strongest. A recent study shows that the elderly under Medicare have markedly worse health outcomes when they are treated in HMOs than in traditional fee-for-service systems.

Patients are also losing another essential—the sense of trust they should have that their physicians are acting in their best interest and not bound and gagged by HMO rules and limitations on care.

Whoever will be making rules in Washington next term will be tempted—probably beyond their powers to resist—to respond to voters' discontent and pass laws trying to curb or correct HMO problems.

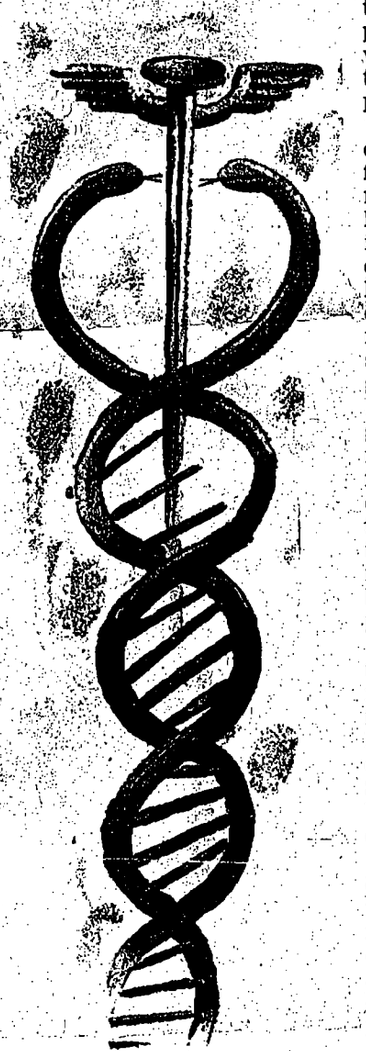


Illustration by Robert Neubecker

Is this any way to run a health-care system? Must we let the financial markets dictate how much medical care we can get? Dare we rely on politicians to interfere fast enough and wisely enough? Will we need more lawyers and lawsuits to get, for a current example, breast reconstruction after cancer surgery? What should government do?

Certainly there is a role for government, for example, in making sure ample research funds are available to find new drugs and new treatments—including funds for training specialists. Perhaps managed care organizations could be required to contribute a percentage of their income.

Legislation might be considered to require employers and insurers to offer employees a fee-for-service option, perhaps at higher cost, instead of pushing everyone into managed care. Seniors on Medicare should not be pressured into HMOs in hopes of saving the government money.

Gag rules in managed-care contracts should be banned as an unconscionable infringement on free speech and a breach of doctor-patient trust. Some sort of appeals board to adjudicate disputes between HMOs and patients might be set up to reduce lawsuits and keep sick people from waiting for months for treatment.

Next month, California voters will have to decide on several bitterly contested proposals dealing with managed-care regulations, doctors' pay, executives' compensation and new managed-care taxes. Federal laws may not be far behind.

This is supposed to be a free country. But how can we be free people if we are losing control over our own bodies and the care we can get when we are ill and elderly?

—— rm 223

Pauline –

These are the breast cancer / wmn's health talking pts prepared for HRC, as we discussed.

—— Nicole

FIRST LADY HILLARY RODHAM CLINTON
GOOD SAMARITAN HOSPITAL
WEST PALM BEACH, FLORIDA
OCTOBER 1, 1996

[Acknowledgements: TBD]

- It's a pleasure to be here today for this dedication. Your new facility, by providing so many services for women under one roof -- from education to screening to treatment -- is an example of how common sense solutions can be effective in combating breast cancer. With breast cancer now striking one out of eight American women, your facility serves as an example for other medical institutions across the country.

- I have been heartened as I travel around the country to see more and more people coming together in the fight against breast cancer. Just last week at the White House we hosted Princess Diana and representatives of the fashion industry, whose tireless work has not only brought public attention to the disease, but also has been instrumental in raising millions of dollars for much needed research.

- The President has committed his Administration to a leading role in this effort:

- Since 1993, the Department of Health and Human Services' funding for breast cancer has ~~nearly~~ doubled and now stands at ~~$476~~ $531 million. Total funding for breast cancer research, prevention, and treatment services through the National Cancer Institute, the Department of Defense, and other agencies has increased six-fold since 1990.

- In 1993, the President established the National Action Plan on Breast Cancer, an innovative public-private partnership to develop a national strategy to address issues in research, treatment, and education about the disease. The Plan has awarded nearly 100 grants to worthy research and outreach projects.

- Bringing together patient advocates, physicians, scientists, and government officials, the Plan has shepherded progress on many fronts. It is addressing the complex issues surrounding the identification of breast cancer susceptibility genes, boosting research into the environmental causes of the disease, increasing awareness and participation of women in clinical studies, and educating more Americans about the disease through a website on the Internet.

- For its' part, the FDA has put all cancer drugs on the fast track for the review and approval so that cancer patients will have as many treatment options as possible.

- In the absence of a cure, we must do everything we can to encourage early detection of the disease. As you know, mammograms are the key to early detection. The FDA has developed a certification program to make sure that all mammography facilities

meet the highest possible standards in equipment and personnel.

- To make sure that as many women as possible can take advantage of mammogram technology, the Centers for Disease Control and Prevention currently offers free or low-cost tests to thousands of medically-underserved women.

- Sixty percent of all breast cancers occur in women over 65. That is why the President is supporting efforts to make mammograms, which are currently available to women every other year through Medicare, an annual benefit.

- Last year, I was surprised to find out that fewer than 40 percent of eligible women took advantage of the benefit. So, last Mother's Day we started the Mama-gram campaign to educate older women about the importance of mammograms.

- Innovative partnerships are also making advances in the technological aspects of breast cancer detection. NASA, the Defense Department and the CIA have joined our Public Health Service's Office on Women's Health in the fight against this disease.

- Computer programs used to simulate three-dimensional missile launches are being used to give us clearer, more detailed images to help doctors distinguish between benign and malignant tumors and to determine the size and spread of the tumor.

- Government researchers are now beginning clinical trials with these technologies and with a little luck, they will enhance our ability to detect cancer at its earliest stages.

- This progress gives us hope that breast cancer will soon be conquered. Thank you for your efforts and your commitment to helping the millions of American women and their families who are affected by this disease.

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Hubble Telescope Reveals Galaxies Housing Quasars

But the Pictures Create New Questions, Too

By JOHN NOBLE WILFORD

CAPE CANAVERAL, Fla., Nov. 19 — Ever since the discovery of quasars, the universe's most powerful objects, in 1963, astronomers have been trying to figure out where they reside and what forces could account for the tremendous energies coming from such distant sources not much bigger than the solar system.

The working hypothesis has been that quasars occur at the cores of galaxies where black holes, concentrations of mass with incredible gravitational strength, gobble up surrounding stars and gases. The black hole's gravity heats up the material it is devouring, sometimes producing the energies that outshine galaxies of hundreds of billions of stars.

But what kinds of galaxies are home to quasars? In telescope observations, a quasar's blinding light invariably obscured its surroundings. It was like driving at night in a snowstorm, as Dr. Mike Disney of the University of Wales in Cardiff put it. Astronomers could see the bright lights but not the "vehicles" from which they came.

Now the Hubble Space Telescope has pierced the snowstorm, revealing for the first time the galaxies that are hosts to quasars, the National Aeronautics and Space Administration announced today.

As often happens in science, however, the observations of 35 quasars left astronomers with possibly more questions than answers. Quasars do abide in galaxies, as expected, but the telescope's pictures showed them in galaxies of many different shapes and sizes, with no pattern apparent. Many of the galaxies were colliding with each other, the kind of violent phenomenon that had been theorized as a trigger for quasars, but almost as many showed no signs of collisions.

The leaders of the two teams reporting the research, Dr. Disney and Dr. John N. Bahcall of the Institute for Advanced Study in Princeton, N.J., said they had no ready interpretation for the findings.

"If we thought we had a complete theory of quasars before, now we know we don't," Dr. Bahcall said. "No coherent, single pattern of quasar behavior emerges. The basic assumption was that there was only one kind of host galaxy, or catastrophic event, which feeds a quasar. In reality, we do not have a simple picture — we have a mess."

Still, astronomers found reasons to feel reassured by the results.

At a news conference at NASA's headquarters in Washington, Dr. Bruce Margon, an astrophysicist at the University of Washington in Seattle, who was not a member of the discovery teams, said: "What we are seeing now is the conclusive proof. The homes of quasars are now evident without any ambiguity."

An analysis of the Hubble telescope pictures showed beacons of quasar light shining out of normal spiral galaxies, much like Earth's Milky Way, and also elliptical galaxies. In some cases, the forces fueling the quasar appear to have had no disturbing effect on the galaxy's shape.

Astronomers once speculated that some quasars might be unaccompanied by galaxies. These became known as "naked quasars." At least one of the quasars observed by the Hubble telescope seemed to exist in only the wispiest of galaxies.

"It may not be naked," Dr. Bahcall said, "but it is poorly clothed."

Dr. Disney said it was also important to have confirmation that collisions of galaxies could be a factor in feeding black holes, thus generating the energies emitted by quasars. The puzzle, he added, is that so many other colliding galaxies do not appear to have quasars, suggesting that other subtle forces may be at work.

Observations that leave astronomers with more questions than answers.

It also could be, astronomers said, that some colliding galaxies lack black holes to pull in stars and gases at high energies. Or it could be that quasars are short-lived events and their moment of brilliance in many galaxies has already come and gone, as the black holes consume all nearby matter, or have yet to be "turned on."

Dr. Alex Filippenko, an astronomer at the University of California at Berkeley, noted that some of the observed quasars did not appear to be emitting radio waves. These quasars are often in elliptical galaxies, not always in spiral galaxies, as previously thought.

Astronomers offered two possible explanations for the absence of radio emissions. One is that such emissions are even more short-lived than the quasars themselves, and so could have already faded away. Another possibility is that radio emissions of some quasars could be pointed away from Earth.

U.S.'s Rate of Sexual Diseases Is Highest in Developed World

By WARREN E. LEARY

WASHINGTON, Nov. 19 — The United States has the highest rate of sexually transmitted diseases of any developed country in the world and no effective national system to combat the epidemic, a panel of health experts said today.

Although all of the dozens of sexually transmitted diseases to which Americans are exposed are preventable, each year these diseases cause thousands of deaths and such serious health problems as cancer, said a committee of the Institute of Medicine, a branch of the National Academy of Sciences.

The 16-member committee, which included researchers, doctors and public and private health experts, said the fight against sexually transmitted diseases had been hampered by too few resources being put into prevention and a lack of involvement among private organizations, many health providers and community groups.

"We need to fight this hidden epidemic by bringing together entire communities to promote healthy sexual behaviors, protect adolescents, provide high-quality clinical services and energize strong leadership in the fight," said Dr. William T. Butler, chancellor of the Baylor College of Medicine in Houston and chairman of the committee.

The committee, which spent 18 months studying the problem, said all levels of government spent only $1 to prevent sexually transmitted diseases for every $43 spent on treatment and other costs. In all, these diseases cost the nation at least $10 billion a year, not including the cost of sexually transmitted H.I.V., the virus that causes AIDS, it said.

The most common sexually transmitted diseases include chlamydial infection, syphilis, gonorrhea, herpes and hepatitis B virus. Left untreated, sexually transmitted diseases can cause infertility, cancer, birth defects, miscarriages and even death.

The report said international studies showed the rates of sexual diseases in the United States exceeded those of every other developed country. It noted, for example, that gonorrhea infects 150 of every 100,000 Americans, compared with 3 of every 100,000 people in Sweden and 18.6 per 100,000 in Canada.

The report said one-fourth of the estimated 12 million new cases that occur each year involve adolescents, who are at greater risk because they are more likely to engage in more unprotected sex and other high-risk sexual behavior than adults. Because the effect of sexually transmitted diseases on young people is so great, special preventive efforts are needed to reach them, it said.

Adolescents should be strongly encouraged to delay sexual intercourse, the report said, but those who are sexually active need access to information on sexual diseases and ways to prevent them, including access to condoms, testing and treatment.

Dr. David Satcher, director of the Centers for Disease Control and Prevention, a Federal agency whose headquarters are in Atlanta, praised the report, saying the agency would use the study to help inform people about the urgency of the problem.

The centers, the chief Federal agency in the fight against sexual diseases, now spends about $106 million a year to combat them, not including the money it spends to help curb H.I.V. infection. Most of the $106 million is used to support state and local programs, Dr. Satcher said.

"We have the tools to stop sexually transmitted diseases, but we need to be more aggressive in using them," he said in an interview. "We need to muster schools, local groups, churches, managed care organizations like HMO's, and government at all levels to make a difference."

Dr. Nancy E. Adler, a member of the committee and director of the Health Psychology Program at the University of California at San Francisco, said the committee realized that some of its recommendations, including those involving sex education and the use of condoms among young people, could be controversial.

"We hope it helps to have such an august group as the Institute of Medicine focus on the issue and spotlight the cost to society of not addressing these issues realistically," Dr. Adler said in an interview.

The New York Times

WEDNESDAY, NOVEMBER 20, 1996

Valujet Fire May Have Been Roaring Inferno, Expert Says

By MATTHEW L. WALD

MIAMI, Nov. 19 — The fire that brought down Valujet 592 may have reached 3,000 degrees Fahrenheit, hot enough to burn stainless steel, according to a National Transportation Safety Board expert who showed a videotape today of a roaring, white-hot fire fed by oxygen generators of the kind the DC-9 was carrying.

For years, the Federal Aviation Administration has contended that cargo holds of the kind where the fire occurred are safe because they are airtight and would smother a fire. But the holds are made mostly of aluminum, which melts and even burns at temperatures far below 3,000 degrees.

The testimony of the fire expert, Merritt Birky, came on the second day of the safety board's hearings being held here on the crash, which occurred on May 11 in the Everglades, just west of Miami. Technical experts also questioned people who load and unload planes on how the oxygen generators had been handled and attempted to show that the fire might have begun well before the plane took off. If that is true, fire detection and suppression systems, which the board first recommended in 1988, would almost certainly have saved the 110 people on board, all of whom were killed in the crash.

"The time to flaming combustion was about five to seven minutes after initiation of a generator," said Dr. Birky, referring to several tests. After the plane pulled away from the terminal, 20 minutes passed before it started to take off.

"In my experience in fires, in 30 years, this is the hottest fire I've ever seen in the test apparatus," said Dr. Birky, who is also the lead fire expert in the investigation of Trans World Airlines Flight 800, which crashed off Long Island on July 17.

The F.A.A. said late last week that it would draft rules to make fire detection and suppression systems mandatory on cargo holds like the one on the DC-9.

The oxygen generators are ordinarily carried as emergency equipment, but they were being carried as cargo on the Valujet plane and were activated in flight because they had been improperly packed, the investigators believe. Dr. Birky showed two videotapes of test fires, conducted at a Federal Aviation Administration laboratory early this month, that produced roars and fricative sounds like the air being let out of a balloon.

The company that packed the oxygen generators, Sabretech, a maintenance contractor, had objected vehemently to showing the videotape. Company officials said the test was not representative of conditions on the Valujet plane. But the hearing officer, John Goglia, a member of the safety board, threatened to eject Sabretech from the proceedings here for making its objections public in a letter it handed out at the hearing.

Mr. Goglia also tangled with Lewis Jordan, the chairman of Valujet. Mr. Goglia, a former official of the International Association of Machinists, cited F.A.A. statistics showing that Valujet had 15 unscheduled landings in 1994, a year in which it had only a handful of planes, and 56 such landings in 1994.

In the first five months of 1996, until the airline was grounded by the F.A.A., Valuejet had 59 unscheduled landings. "That's a rate that's approaching four per week," said Mr. Goglia, who said he was "very concerned." He also pointed out that the airline's accident rate per 100,000 departures, a statistic "deigned to level the playing field between big guys and little guys," had been 10 times as high for Valujet, compared with eight large airlines.

Mr. Jordan said, "This is one of the statistical anomalies that concerns me a great deal." But he argued that the unscheduled landings had been for mostly minor problems and had occurred during a particularly rough period for the airline.

Other safety board officials asked whether the pay policy initially used by Valujet had been detrimental to safety. Under that policy, a pilot who diverted a plane to an airport other than the original destination was not paid for the flight.

Mr. Jordan said it insulted the integrity of pilots to think that they would take their pay into consideration in making safety decisions.

In response to a question, Mr. Jordan also said that he had not been aware before the accident of an ambiguity in the rules that the safety board has been focusing on: airlines that have not qualified to carry hazardous materials as cargo, like Valujet, sometimes carry such material when they own it themselves.

Mr. Jordan was escorted from the hearing room by a security guard, the only witness so accompanied.

Apart from that disagreement, the hearings have been unusually quiet.

Before the hearings began, Valujet and Sabretech, a subsidiary of Sabreliner Corporation, had blamed each other for the crash. At the hearings, they have consistently declined to cross-examine each other's witnesses, who have made contradictory statements about who was responsible for handling the oxygen generators safely.

A spokesman for Valujet, Gregg Kenyon, denied that any agreement had been reached between the companies, and he said the Sabretech personnel whom Valujet really wanted to cross-examine were lower-level people who have not been called to testify because they told investigators they would invoke their Fifth Amendment protection against self-incrimination.

A lawyer for Sabretech, Kenneth Quinn, said that because of Mr. Goglia's admonitions, he could not respond at all to the question of whether an agreement had been reached.

Mr. Goglia said after the hearing today, "I would have expected more questions, but it's their call."

Cross-examination by parties in the hearings can clarify complicated points, Mr. Goglia said, and "the lack of questions must indicate the safety board must be doing a good job of bringing out accurate, factual information."

Other participants in the hearings said they suspected that the parties had reached at least a tacit agreement not to attack each other in public.

Also today, as investigators struggled to determine precisely how the generators had been packed and placed on the plane, they themselves experienced a problem that they think may have created confusion in the Sabretech hangar that led to the accident: a language problem.

One witness was Christopher Ramkissoon, the Valujet employee who supervised the workers loading the plane, and the panel had trouble understanding him. Mr. Ramkissoon, for example, had to repeat the word "manual" three times before it was understood. After testifying, Mr. Ramkissoon said he was from Trinidad.

Investigators believe that some Spanish-speaking technicians in the Sabretech hangar did not know enough English to understand the technical manuals on the safe handling of oxygen generators.

The New York Times
WEDNESDAY, NOVEMBER 20, 1996

Quality of Life Is Up for Many Blacks, Data Say

A1

By STEVEN A. HOLMES

INDIANAPOLIS — Four years ago, officials here in Marion County decided to make an all-out effort to curb the stubbornly high level of births among unmarried women, a problem that affected a cross-section of the county, but was particularly acute for blacks.

The health department, public and private social service agencies, the schools, even the local prosecutor's office, all joined in to help. Last year the effort seemed to pay off: 358 fewer babies were born to unmarried black women than in 1992, a drop of more than 12 percent, within a 4 percent overall decrease in Marion County.

The county's success in confronting what was a seemingly intractable problem among its black population is a small victory but not an isolated one. Without much fanfare, a remarkable and little understood change is occurring among the nation's 33.5 million African-Americans. After a decade of rising drug use, growing violence, disintegrating families and declining measures of health among some segments of the black population, things are starting to turn around in many ways.

While there is much debate on whether the gains are temporary, and although wide gulfs in opportunity, incomes and education still exist between blacks and whites, signs of improvement abound:

¶The black teen-age birth rate fell by 9 percent in 1995 and has dropped by 17 percent since 1991. Last year, the percentage of black babies born out of wedlock fell to 69.5 percent, from 70.4 percent, the first such drop since 1969.

¶For the first time since the Census Bureau began keeping track in 1959, the poverty rate fell below 30 percent of all blacks in 1995. Median income for black households rose by 3.6 percent, far faster than the 2.2 percent increase for white households. (Census data show that many of the strongest gains in earnings are at the bottom, rather than at the top, of the black income scale.)

¶Blacks are the only group whose inflation-adjusted median income exceeds what it was in 1989, the year before the last recession. In 1989, households headed by black married couples earned 79 percent as much as their white counterparts. By 1995, the gap was 87 percent.

¶The rate at which black people were victims of murder dropped an estimated 17 percent last year, and the average life expectancy for black men rose to 65.4 years, the highest since 1984, when crack cocaine and accessibility of weapons like assault rifles began to engulf many black communities.

¶The proportion of young black adults, age 25 to 29, who have completed high school has reached that of young white adults.

Continued on Page B10, Column 3

Continued From Page A1

¶Verbal scores on Scholastic Assessment Tests and performance on other national tests have been rising faster for black students than for whites, but African-American students still score much lower than white students.

"I think that this is a short period of really very substantial and significant gains," said Milton Morris, vice president of the Joint Center for Political and Economic Studies, a Washington group that tracks trends among African-Americans. "In the heat of the political debates and atmosphere of the last year or so, very few people have been paying serious attention. And yet when you do, you see that by virtually every measure of well-being, African-Americans have been on a significant uptrend during the 90's."

To be sure, there remain large gaps between African-Americans and whites in educational attainment, infant mortality, income and poverty rates. And sociologists, economists, demographers and civil rights advocates caution that the improvements should not mask continued problems with crime, welfare dependency, discrimination and unemployment that still confront the black population in this country.

"I don't know that I can agree with how robust those indicators are in terms of significant gains," said Evelyn Moore, the executive director of the National Black Child Development Institute, a nonprofit advocacy organization in Washington. "I think there are still very serious challenges facing our children."

Some scholars also worry that the recent gains may be reversed if the economy falters or, in the short term, by the new welfare law.

"I think there's reason to be concerned about the impact of the welfare bill on a number of these trends, on the poverty rate, on the employment rate," said William Julius Wilson, a professor of social policy at the John F. Kennedy School of Government at Harvard University. "When the welfare mothers reach their time limit, they will flood a pool that is already filled with a lot of jobless workers."

Still, in public hospital waiting rooms, in medical clinics and in the offices of social welfare programs around the country, workers point to glimmers of improvement even with poverty and hopelessness.

Jarvis Emerson, the director of the school-based program for the Watts Health Foundation, a nonprofit group in the South-Central section of Los Angeles, said he was beginning to notice gains in the struggle to reduce the soaring rates of out-of-wedlock births in the neighborhood.

"I do think it is a slight decrease or leveling off of births to teen-agers," he said. "With all the programs out there all putting out the same message, there is more of a heightened awareness among the young people of becoming pregnant."

Diane Sawyer, who works in the G.E.D. program at Jefferson State Junior College in Birmingham, said more black students were taking the test each year. Lisa Crumley, a supervisor with the Department of Human Resources in Bessemer, a suburb of Birmingham, said fewer black people had applied to her office to receive welfare benefits in recent months. "I don't know if that means the quality of life has improved or what," Ms. Crumley said.

In Camden, N.J., there was a 21.2 percent drop in the number of births to mothers on welfare there from 1992 to 1994, according to Gary Young, a researcher at Cooper Hospital-University Medical Center in Camden, and Ted Goertzel, a sociology professor at Rutgers University.

Scholars who study America's black population give much of the credit for the improvements to the country's overall economic prosperity, though they acknowledge that better economic times cannot explain the whole story. A number of economists and sociologists note that in 1995 the black unemployment rate tumbled under 10 percent for the first time in 20 years, though it has since inched up above that level.

But while a brighter labor market helps account for black gains in income and the drop in poverty rates for African-Americans, many experts cannot fully explain improvements in the out-of-wedlock birth rate or the teen-age pregnancy rate.

Some researchers in New Jersey credit the drop in the out-of-wedlock birth rate among the state's welfare families — about 46 percent of whom are black — to its 1992 law denying increased cash benefits to women who have more children. Other states, like Delaware and Indiana, which did not institute policies like New Jersey's until recently, have also reported such decreases.

"Something is going on," said Kristin Moore, the executive director of Child Trends, a Washington-based research group. "Whether it's cul-

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tural factors, or a thousand programs finally seeing some success, we don't know."

A growing sense of material well-being is even changing the makeup of the military. The Pentagon recently found that the number of blacks joining the armed forces has fallen by about half since 1990, a steeper decline than for any other group. Defense Department and civilian analysts are unsure of the reason, but one theory is a growing confidence among blacks in their ability to succeed in the labor market.

Some economists argue that the closing of the gap between blacks and whites is partly explained by surveys that often count most Americans of Hispanic heritage as whites. Recent increases in the number of Hispanic immigrants, many of them low income, thus hold down overall white performance.

Some economists also say the nearly 800,000 black adults in Federal and state prisons and local jails are not counted when looking at things like unemployment or high school completion rates. So the measures of black improvements seem higher than they actually are.

"Those people are gone from all these employment and earnings statistics," said Richard Freeman, a professor of economics at Harvard. "Those are huge numbers."

But there is disagreement over how much these two phenomena affect the overall picture, and some sociologists say whatever distortions that occur only show up when comparing achievement among blacks to that of whites, not when looking at black improvements by themselves.

"Some figures would be different if they were counted, but I don't think the overall trends would be affected," Professor Wilson said of the numbers of black men in prison.

Across the country, from Jersey City to Cleveland to Los Angeles, the signs of improvement are also beginning to be felt among the people.

"In my area, I see things getting better all the time," said Felicia Wearing, 25, who lives with her daughter in the Bergen Lafayette section of Jersey City. "It used to be like hell, groups always on the corner, cussing and fighting, ripping and raiding, shooting each other. It's calmed down a whole hell of a lot."

Chuck Wheeler, 39, a former drummer who bought an aging laundry in a black section of Cleveland, also senses a change. "People are not doing the same things they were doing before," Mr. Wheeler said. "People are waking up. They're realizing what they need to do is get their families and themselves together."

But not everyone is convinced that things are improving. "To tell you the truth, I really think things are going back," said Harold Truxon, a black community activist from Ellendale, Del. "I really see more problems than I ever have."

In his own way, Richard Edwards of Indianapolis is symbolic of the changes. A little more than a year ago he was selling and using drugs. He never spent any time in prison, but he had been arrested on narcotics charges and had been given probation. A high school dropout, he also spent very little time with the son he had fathered out of wedlock.

Today, at 26, he is living with his girlfriend and spending time with his son. Mr. Edwards said he had no intention of having more children until he was married and financially able to provide for them. He is studying for a G.E.D. and is working as a maintenance mechanic at a hospital.

"I've been here 10 and a half months," he said, smiling and clutching a practice test for his G.E.D. "I've never held a job that long."

In October 1992, health officials in Marion County, Ind., surveyed all women who gave birth there. Among the results of the survey was a startling discovery: more than 90 percent of the unwed mothers said they had not tried to get pregnant. Officials saw an opportunity to make a dent in the illegitimacy rate.

Now, all major hospitals in the county offer family-planning programs, as do clinics and classes run by the county health department and private agencies like Girls Inc. and Planned Parenthood.

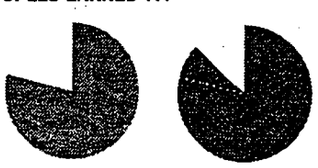
Recently, a local middle school and a high school have begun giving boys and girls life-like computerized dolls that are programmed to cry at random. To teach youngsters that parenthood brings responsibilities that do not end, the students must cart around the dolls even on weekends or arrange for a baby-sitter.

But even as officials take note of progress, people like Virginia A. Caine, the director of the Marion County Health Department, worry about complacency.

"People's perception," Ms. Caine said, "is that we've solved the problems and we don't have to put as many resources into it. Let's focus our attention on something else. People have no idea the amount of effort it requires to get people to receive services and to change their lives."

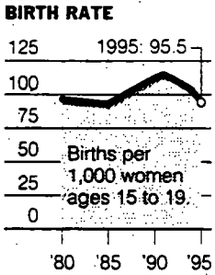
BLACK MARRIED COUPLES EARNED ...

IN 1989
... 79% as much as white married couples.

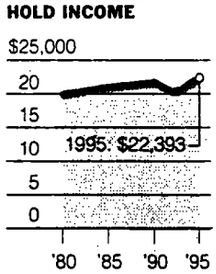


IN 1995
... 87% as much as white married couples.
Based on median household income.

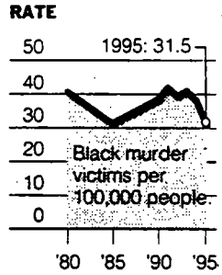
TEEN-AGE BIRTH RATE



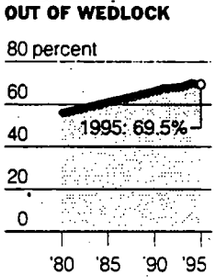
MEDIAN HOUSEHOLD INCOME



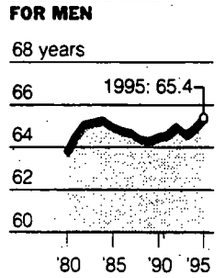
HOMICIDE RATE



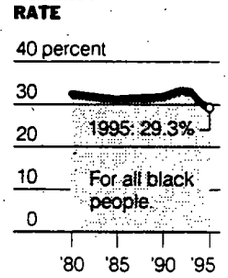
CHILDREN BORN OUT OF WEDLOCK



LIFE EXPECTANCY FOR MEN



POVERTY RATE



Sources. Census Bureau; National Center for Health Statistics

The New York Times

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SUSAN J. BLUMENTHAL, M.D., M.P.A.

DEPUTY ASSISTANT SECRETARY FOR HEALTH (*WOMEN'S HEALTH*)

ASSISTANT SURGEON GENERAL

To:	Pauline	**Date:**	11 | 21 | 96
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COMMENTS: As requested.

U.S. Public Health Services - Office on Women's Health
200 Independence Avenue SW, RM 712-E
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PH: 202-690-7650 Fax: 202-401-4005

Waging the Battle Against Breast Cancer

An Administration Report Card

Breast cancer — the most commonly diagnosed cancer and the second leading cancer killer of American women — affects one in eight women in their lifetimes. But, thanks to this Administration's commitment, there is good news in the battle against breast cancer. It has become a top national health priority. The product is being measured in increased knowledge of the causes of the disease, improved methods of early detection, and the availability of more effective treatments. For the first time in recent history, the death rate from this disease is dropping.

Significantly Increasing our National Investment

Federal funding for breast cancer research, prevention, and treatment services has increased dramatically — over six fold — from $90 million in 1990 to over $600 million today.

- ☑ The Department of Health and Human Services' funding for breast cancer has nearly doubled between 1993 and 1996 — from $271 million to $476 million — an increase unrivaled in recent history. Since 1993, the Department of Defense has committed over $450 million to breast cancer research programs.
- ☑ President Clinton directed the establishment of the National Action Plan on Breast Cancer — an innovative public-private partnership to coordinate a national strategy that is catalyzing action in research, service delivery and education about this disease. The Plan has awarded nearly 100 grants for innovative research and outreach projects.
- ☑ All Federal agencies have been mobilized to join in the battle against this disease with the establishment of a Federal Interagency Coordinating Committee on Breast Cancer.
- ☑ The latest breast cancer information is now available from the National Cancer Institute free by phone (1-800-4-CANCER) and on the Internet (Gopher @nih.gov).

Intensified Research Brings New Hope

A broad spectrum of new research is being supported that holds promise for increased understanding of the causes of the disease and for the development of new diagnostic, treatment, and prevention strategies.

- Researchers supported by the National Institutes of Health have identified breast cancer susceptibility genes that place women at increased risk of the disease. These findings hold promise for the development of improved treatments and potentially, to gene therapies that will prevent the disease from developing. The National Action Plan on Breast Cancer has published recommendations to address the legal and ethical issues arising from discovery of these genes.
- The National Institutes of Health and the Environmental Protection Agency have increased the research focus on the study of environmental risk factors for breast cancer. And a new Federal Interagency Coordinating Committee on this issue is examining how home, work, diet, atmospheric pollutants, drugs, and other environmental factors may contribute to the risk of breast cancer and other diseases and developing strategies to prevent these health hazards.

Ensuring Accurate and Early Detection of Breast Cancer

Mammography detects breast cancer early, when treatment is most effective. New advances in imaging technology will enable the disease to be detected even earlier and with greater accuracy.

- To ensure that women get the safest and most reliable mammography, the Food and Drug Administration has implemented the Mammography Quality Standards Act. Now, an FDA "seal of approval" assures women that their mammography facility meets the highest quality standards for equipment and personnel. Without this certification it is illegal for facilities to operate.
- The National Breast and Cervical Cancer Early Detection Program, implemented by the Centers for Disease Control and Prevention, makes free or low-cost mammography and Pap tests available to medically underserved women. To date, over 800,000 screening tests have been performed.
- Because older women were not using Medicare's new mammography screening benefit, an educational campaign to encourage its use was launched by the First Lady with the Health Care Financing Administration and the U.S. Public Health Service's Office on Women's Health.
- New imaging technologies are being developed and tested to improve the early detection and diagnosis of breast cancer, including magnetic resonance imaging, digital mammography, and image-guided needle biopsy. And technologies from the CIA, DoD and NASA used to track spy satellites, to guide missiles, and to see distant planets are being applied to improve the early detection of breast cancer.

Treatment Advances

- The Food and Drug Administration has put cancer drugs on a fast track for review and approval. For example, medications approved in other countries or those found to shrink tumors will be made available to treat severely ill breast cancer patients.
- New treatment approaches are evolving, including the sequencing of chemotherapies, the development of monoclonal antibodies shown to boost the immune system to fight cancer growth, new drugs for advanced breast cancer, and medications to help prevent the disease from occurring.

These Federal programs and many more initiatives being supported by the government and the private sector are making significant progress in the battle against breast cancer.

Prepared by the U.S. Public Health Service's Office on Women's Health
Department of Health and Human Services
For more information, contact: (202) 690-7650

Improving Health Care Services for all Women

Improving and targeting health care services to all women will safeguard their health today and tomorrow.

- ☑ Implementation of the Mammography Quality Standards Act by the Food and Drug Administration ensures that women today will get the safest and most reliable mammography in their communities. And a nationwide early breast and cervical cancer screening program, conducted by the Centers for Disease Control and Prevention (CDC), is making these life-saving screening tests available to medically-underserved women.
- ☑ A National Sexually Transmitted Disease (STD)-related Infertility Prevention Program, conducted by the CDC, is combating STDs, particularly chlamydia — the most common, yet least readily diagnosed STD affecting American women and one that often leads to chronic pelvic inflammatory disease and subsequent infertility. New federal guidelines recommend annual screening for this disease.
- ☑ HHS is implementing a major initiative, "Safe Passages", to promote healthy and productive transitions from childhood to adulthood. Girl Power!, a series of programs targeting girls, includes a public information campaign to help delay the onset and reduce the use of illegal drugs among girls between the ages of 9-14 years.
- ☑ An educational campaign to end the epidemic of adolescent smoking. This is of particular importance for girls and young women who represent the fastest growing segment of the population who smoke.
- ☑ A new Presidential Directive on Emerging Infectious Diseases has set the policy and provides coordination across government agencies to improve the surveillance, prevention, and national response to infectious diseases. Although no longer the primary killers of women, today, infectious diseases like HIV, tuberculosis, and Lyme disease have become major health threats to women.
- ☑ New programs to fight the epidemic of domestic violence are being implemented. A National Advisory Council on Domestic Violence has been established to develop strategies to eradicate this public health problem from our communities. Increased funding has been provided for the development of intervention and prevention programs, as well as for training of health care professionals.

These Federal programs and many more initiatives being supported by the Government and the private sector are making significant progress in improving women's health in this decade and beyond.

Prepared by the U.S. Public Health Service's Office on Women's Health
Department of Health and Human Services
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Washington, D.C. 20201
For more information, contact: (202) 690-7650

Progress in Advancing Women's Health

An Administration Report Card

Improving women's health is a top Administration priority. Through government-sponsored public health interventions, today women live 30 years longer than they did at the turn of the century. In the year 1900, women died on average at age 48. Today, women die on average at age 79. The major killers of American women are now chronic diseases, including heart disease, cancer, stroke, chronic lung disease, and diabetes.

Since 1990, alarming inequities in women's health have been exposed — inequities that include the failure to include women in research studies; the inadequate attention to gender differences in the causes, treatment, and prevention of disease; the lack of funding for women's health concerns; the lack of public and health care professional education on women's health issues; the lack of women's access to health care services; and the dearth of women in senior medical and scientific positions in our Nation's health and research organizations.

Today, this Administration is writing a new national prescription to improve women's health. The result is the greatest focus on women's health in the history of our country.

A New National Focus on Women's Health

Today, a new national focus on women's health is brightening the health futures for American women. With funding for women's health over $2 billion this year in the Department of Health and Human Services (HHS) alone — an increase of over $650 million in just three years — this Administration is intensifying research, developing innovative public and health care professional education programs, and designing targeted health care services for women.

- Federal departments, agencies, and offices as well as private sector organizations have been mobilized to advance women's health.
- To coordinate and stimulate these efforts, a new senior level health position was created. The first Deputy Assistant Secretary for Women's Health was appointed to direct the U.S. Public Health Service's Office on Women's Health that coordinates and stimulates women's health research, service delivery, and education programs across the agencies and offices of the Department of Health and Human Services.
- For the first time, all of the *HHS* offices, agencies, and regions have established offices and/or coordinators of women's health to stimulate new initiatives on women's health issues.
- President Clinton directed the establishment of the National Action Plan on Breast Cancer — an innovative public-private partnership to coordinate a national strategy that is catalyzing action in research, service delivery, and education about this disease. Funding for breast cancer programs has increased from $90 million in 1990 to over $600 million today.

Intensifying Research and Improving Treatments

Since 1950, we have learned more about health and disease than in the entire history of medicine. After years of neglecting women's health, advances from new research are leading to improved diagnosis, treatment, and prevention of disease and disability in women of all ages.

- Women and minorities are now included as subjects in government-supported research and in the evaluation of drugs and medical devices. In addition, research is now addressing both gender and racial/ethnic differences in the causes, treatment, and prevention of diseases such as breast cancer, HIV/AIDS, and heart disease.
- Research supported by the National Institutes of Health (NIH) is now focusing on the causes, treatment, and prevention of a broad spectrum of diseases and health concerns affecting women across the life cycle including heart disease, breast and ovarian cancer, and AIDS. Major studies are underway to examine adolescent and mid-life behaviors and their effect on future disease and disability. The Women's Health Initiative — the largest clinical trial ever conducted — is investigating the major risk factors for diseases in older women and evaluating the effects of hormone replacement therapy and behavioral interventions, including diet and exercise, on the health of older women.
- Researchers have identified genes that increase susceptibility to diseases including breast and ovarian cancer and Alzheimer's disease. The promise of these discoveries is the development of more effective treatments and one day, a method to repair gene mutations so the disease does not develop in the first place.
- Imaging technologies from the defense, space, and intelligence communities are being adapted to detect breast cancer and other diseases in women earlier and with greater accuracy.
- Life-saving experimental cancer-fighting medications are now on a fast track for FDA review and approval so that cancer patients will have more treatment options.
- Reproductive health initiatives are being implemented including: efforts to reduce the alarming high teenage and unintended pregnancy rates; developing new and more effective means of contraception; developing new microbicides to protect against STDs and AIDS; examining the causes and designing interventions for infertility; and evaluating alternative treatments for hysterectomy for non-cancerous uterine conditions such as endometriosis and fibroids.

Increasing Public and Health Care Professional Education

To help American women to lead long and healthier lives, new educational initiatives are underway to enhance knowledge of women's health issues and to improve the care that women receive by making sure health care professionals have up-to-date information and training on women's health issues.

- *A National Women's Health Information Center* — a comprehensive resource clearinghouse — is being established to provide the public, health care professionals, and researchers with access to state-of-the-art Federal and private sector information about women's health via a toll-free number and the Internet.
- A nationwide, 24-hour domestic violence hot-line, 1-800-799-SAFE, is providing immediate crisis information and assistance, counseling, and local shelter referrals to women across the country.
- The Substance Abuse and Mental Health Services Administration's *National Women's Resource Center* provides information and referral services (1-800-354-8824) addressing the prevention and treatment of both mental illness and substance abuse.
- *Healthy Women 2000*, a series of health education conferences and educational materials sponsored by the U.S. Public Health Service's Office on Women's Health, focuses on critical health issues affecting women in our country today and on the promotion of good health.
- A video and health promotion education curriculum to encourage healthy behavior among young women has been developed and distributed to college campuses nationwide.
- Educational campaigns are underway to inform health care professionals and counsel pregnant women about HIV testing and treatments to reduce the rate of HIV transmission from mother to child.
- A first medical school model curricula on women's health issues has been developed to bring women's health into the mainstream of medical education. Also, a first of its kind directory of women's health residency and fellowship opportunities in medicine has been prepared and widely disseminated.

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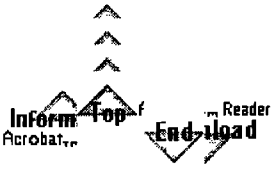

DHHS NEWS
U.S. Department of Health and Human Services

Vital Statistics Report Shows Broad Gains in the Nation's Heath

EMBARGOED FOR: 7 A.M. EDT Friday, Oct. 4, 1996

Contact: NCHS/CDC Press Office, Sandra Smith or Jeffrey Lancashire (301) 436-7551

HHS Secretary Donna E. Shalala today released annual preliminary vital statistics findings for 1995, showing broad gains in national health indicators. According to the report, the U.S. last year achieved:

- an historic low infant mortality rate;
- continued increase in the number of women obtaining early pre-natal care;
- the first decline in the birth rate for unmarried women in almost 20 years;
- continued decline in the teen birth rate;
- a dramatic decline in homicide rates;
- a leveling in the HIV/AIDS death rate, for the first time since the epidemic took hold;
- continued increase in life expectancy.

"Today we have good news about America's health," Secretary Shalala said. "I'm particularly pleased to see that the teen birth rate is continuing to decline, and the out-of-wedlock birth rate has decreased for the first time in nearly two decades. Preventing teen pregnancies has been one of President Clinton's top priorities since taking office, and we must all work together to ensure these trends continue."

"We still have challenges in every category, but we are making significant progress, and we should press ahead toward the goal of better health for all Americans."

The report, "Births and Deaths for 1995," prepared by the National Center for Health Statistics, part of HHS' Centers for Disease Control and Prevention, contains the latest preliminary U.S. natality and mortality statistics. Highlights include:

- The infant mortality rate reached a record low of 7.5 infant deaths per 1,000 live births in 1995, a 6 percent reduction from the previous year. Declines occurred among neonatal infants (infants under 28 days old) as well as postneonatal infants (28 days through 11 months), and among both white and black infants.

- The proportion of mothers beginning care in the first trimester (81 percent) continued to rise for the sixth consecutive year.

- The teen birth rate dropped an estimated 3 percent from 1994 to 1995 (56.9 per 1,000 women aged 15-19) and 8 percent from 1991 (62.1) to 1995. Declines were recorded for white, American Indian, Asian or Pacific Islander, and Hispanic teens; the rate for black teens dropped 9 percent from 1994 to 1995 and 17 percent from 1991 to 1995. This is the fourth straight year that teen birth rates have declined; teen pregnancy rates are also declining.

- The birth rate for unmarried women dropped 4 percent from

46.9 births per 1,000 unmarried women aged 15-44 years in 1994 to 44.9 in 1995. This is the first decline in nearly two decades. The number of nonmarital births also declined three percent in 1995 to approximately 1,248,000, and the proportion of births to unmarried mothers fell two percent to an estimated 32 percent in 1995. The proportions for white (25.3 percent) and black births (69.5 percent) were about one percent lower than in 1994, while the proportion for Hispanic women (40.8 percent) was five percent lower than in 1994. This is the first time that the number, rate, and proportion of births to unmarried mothers have all declined since national data were first compiled in 1940.

- Preliminary age-adjusted homicide rates fell sharply in 1995, by an estimated 15 percent, accounting for the largest decline among leading causes of death between 1994 and 1995. Mortality from firearms also declined between 1994 and 1995.

- For the first time, HIV/AIDS death rates did not increase from the previous year. The age-adjusted death rate from HIV infection was 15.4 deaths per 100,000 population in 1995, the same rate as in 1994. Despite the plateau in mortality rates from HIV/AIDS, however, the number of deaths from the disease rose from 42,114 in 1994 to approximately 42,500 in 1995, the highest total ever reported.

- The cesarean section rate declined for the sixth consecutive year (20.8 percent of live births in 1995).

- Estimated life expectancy in 1995 matched the record high of 75.8 years attained in 1992, and was slightly above the estimate of 75.7 years of 1994. Although racial disparities still exist, life expectancy for both white and black males (73.4 and 65.4, respectively) and black females (74.0) was higher in 1995 than in previous years. For white females, life expectancy was unchanged at 79.6 years from the previous year, and slightly below the record high of 79.8 reached in 1992.

Vital statistics data are issued annually each fall. However, Secretary Shalala said, today's report represents the results of a new initiative to improve the timeliness and quality of vital statistics in the U.S.

These preliminary data are based on up to 90 percent of all birth and death records reported to the states. In the past, "provisional" annual data on deaths were based on a 10 percent sample of records. And this is the first time that detailed birth data have been available on a preliminary basis.

"We're putting a system into place that effectively addresses the growing public demand for faster and more accurate health information," CDC Director David Satcher said. "We are now on a schedule to provide near-final vital statistics at least a year earlier than we used to be able to do."

The report is available from the National Center for Health Statistics, 6525 Belcrest Rd., Hyattsville, Md. 20782 or by e-mail at paoquery@nch10a.em.cdc.gov.

Note: HHS press releases are available on the World Wide Web at: http://www.dhhs.gov.

Births and Deaths: United States, 1995. **Vol. 45, No. 3 supplement 2**. 40 pp. (PHS) 96-1120

397,231 bytes

NCHSTP FACTS

National Center for HIV, STD & TB PREVENTION

November 1996

Decline in Perinatally Acquired (mother-to-infant) AIDS Cases

The National Institutes of Health (NIH) sponsored an AIDS clinical trial, ACTG-076, that was concluded in early 1994 after it indicated that the risk of perinatal transmission of HIV could be reduced by as much as two-thirds with the use of zidovudine (AZT) therapy by HIV-positive pregnant women during pregnancy and childbirth and by their newborns for six weeks after birth.

Following the release of these results, Centers for Disease Control and Prevention (CDC), NIH, and Health Resources and Services Administration (HRSA) began to coordinate efforts designed to capitalize on this research. Guidelines were drafted and issued by the Public Health Service to promote, as standard medical practice in the United States, routine and universal HIV counseling and voluntary HIV testing for all pregnant women and AZT therapy for HIV-infected pregnant women and their babies.

Subsequent research demonstrated progress. For example, a CDC study of a nation-wide cohort of HIV-infected pregnant women and their children indicated that the prevalence of prenatal and/or neonatal AZT use in this cohort increased from 17 percent among women who delivered before the release of the initial PHS Guidelines to 80 percent among those delivering afterwards. Moreover, actual HIV infection rates were almost cut in half; from 21 percent before the Guidelines were released to 11 percent after.

We now have documented evidence that perinatal prevention efforts have dramatically reduced AIDS cases in children.

On November 21, 1996, CDC released in the Morbidity and Mortality Weekly Report (MMWR) information that documents a substantial reduction in perinatally acquired AIDS cases, reported through the National AIDS surveillance reporting system. These data confirm what earlier research indicated; that routine and universal counseling and voluntary testing, combined with AZT therapy is highly effective in preventing HIV.

The MMWR report shows that the incidence of perinatally acquired AIDS peaked in 1992, followed by a short period of stabilization. Cases began to decline in 1993 and dropped dramatically in 1994 and 1995. Researchers believe the small initial reduction indicates possible effects of other preventive and medical factors including an increase in the number of childbearing women receiving AZT therapy for their own health. More dramatic declines in reported AIDS cases in children followed release of the PHS guidelines with a decline of 8 percent from 1993 to 1994 and a drop of 17 percent from 1994 to 1995.

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John

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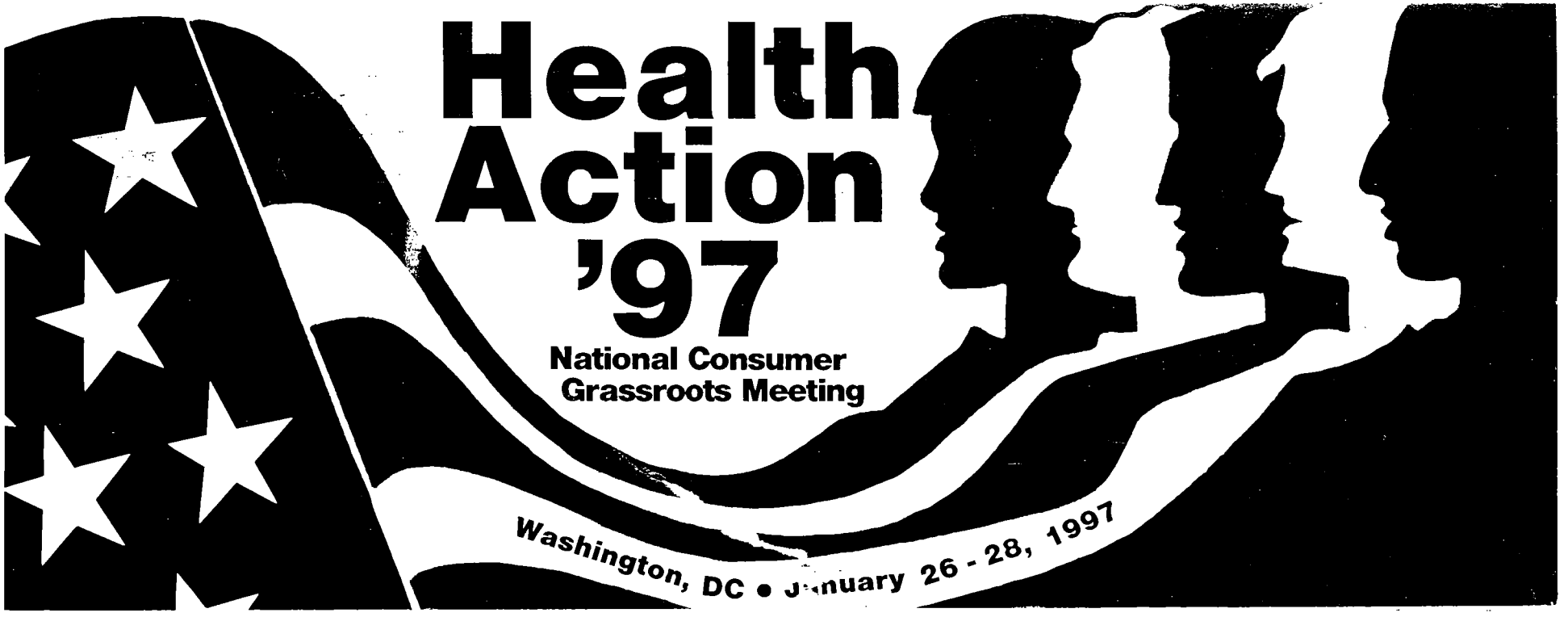
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