

THE WHITE HOUSE
WASHINGTON

November 15, 1996

MEMORANDUM FOR DISTRIBUTION

FROM: PHIL CAPLAN

Secretary Shalala gave the attached memo to the President when she met with him recently. Her office has asked that you get a copy.

Distribution:

Vice President
Leon Panetta
Erskine Bowles
Carol Rasco
Laura Tyson
Frank Raines
John Hilley
Ron Klain



THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

November 14, 1996

MEMORANDUM FOR THE PRESIDENT

FROM: Donna E. Shalala

As we prepare for a second term I wanted to lay out for you, in broad terms, a series of health policies that you might want to consider. These proposals build on the successes of the first term, reinforce commitments made during the recent campaign, and are consistent with your balanced budget commitments.

This proposed strategy should focus on achieving real, sustainable results through practical, incremental reforms. These are not proposals that will significantly increase Federal outlays or impose significant new costs on states and localities.

BUILDING A HEALTHIER, SAFER AMERICA

Consistent with your first term, your goal must be to continue to build a safer and healthier America. We have taken great strides toward protecting and improving the health of the people of our Nation. To build on those successes and continue to fulfill the commitments you have made, we would pursue a series of targeted initiatives to improve the health of Americans and the ability of all our citizens to obtain high-quality, affordable health care. Under the overall theme of "A Healthier, Safer America," I suggest four areas:

- Protecting the health of senior citizens and people living with disabilities: We would stabilize the short-term financing of the Medicare program in the context of the budget, and create a bipartisan commission to devise longer term strategies to address longer-term needs as the baby boom generation retires. Further, we would build on our successes in preserving Medicaid's guarantee of coverage with proposals to make Medicaid more flexible for states while maintaining federal-state accountability.

✓

- **Protecting the health and safety of children:** We will reduce the number of uninsured children, aiming towards a long-term goal of no uninsured children. Our initial strategies would focus on pragmatic building blocks: fulfilling the promise of current Medicaid by reaching 3 million children who are eligible but not enrolled; working with states to address private coverage for "gap" children; and public health strategies--including anti-drug and tobacco efforts--to ensure a safer and healthier environment for children.
- **Protecting the health of working families:** We will pursue your workers between jobs initiative; extension of Medicaid waivers and buy-in options for working Americans; and your proposal for voluntary purchasing cooperatives to enhance the purchasing power of small employers.
- **Providing consumer and quality protections and a Safe America:** We will address concerns about consumer protections and quality of care in the rapidly changing health system through your new national Advisory Commission. We would provide enhanced public health initiatives for a Safer America. We are already well along in plans for two powerful new safety initiatives (modeled on your tobacco strategy) that will affect every American--food safety and injury prevention. These may be great candidates for your State of the Union Address.

Following are brief presentations on our first term accomplishments and on steps to take to address each of these four goals. I look forward to discussing them with you further.

Building a Healthier and Safer America in the First Term

In the last four years, we have taken great strides toward protecting and improving the health of the people of our nation. Moving in incremental steps we have:

- Expanded coverage for 2.2 million Americans through the approval of 15 statewide Medicaid waivers;
- Protected coverage for 25 million working Americans through enactment of the Kennedy-Kassebaum Law;
- Extended the solvency of the Medicare trust fund into the 21st century;
- Reduced the rate of growth in Medicaid spending by nearly 300 percent;
- Enhanced mental health parity in insurance coverage;
- Reduced the rates of teen pregnancy, infant mortality, homicide, and domestic violence to all-time lows;
- Increased the rates of childhood immunization and early prenatal care to historic highs; reduced many common childhood diseases (e.g., measles, mumps, and polio) to record lows;
- Expanded choice in both Medicare and Medicaid while adding important prevention benefits; and,
- Launched major initiatives in important public health areas such as tobacco, dietary guidelines, and physical activity.

Protecting the Health of Senior Citizens and the Disabled

A. Medicare

One of our first priorities must be to stabilize the short-term financing of the Medicare program while moving forward toward a long-term plan to address the problems created by the retirement of the baby boom generation.

1. Short-Term Plan

As part of the fiscal year 1998 budget, we should move early in 1997 to secure passage of a package of Medicare reforms that will extend the solvency of the HI trust fund. It is important to note that a comparison of our balanced budget plan and that of the Republicans indicate many areas of agreement that could form the basis of a bipartisan package. While the details of this plan will have to be tailored to fit the framework of your revised balanced budget plan, they should include:

- Modernizing the Medicare program by offering beneficiaries much greater choice of health care delivery models while protecting the essential right to exercise that choice without penalty;
- Expanding the array of benefits to include respite benefits for the families of Alzheimer's disease patients; diabetes education and screening; and annual mammograms;
- Reducing the rate of increase in payments to hospitals, physicians, durable medical equipment suppliers, and other providers;
- Reforming the way Medicare pays for graduate medical education;
- Reforming the physician payment target and update systems; and,
- Extending the Part B premium at 25% of program costs.

2. Long-Term Plan

There is clear bipartisan support to create a national commission to undertake the important task of studying the long-term needs of an aging society and its implications for the Medicare program and help devise a strategy to preserve the solvency of the program well into the 21st century. There are several options available to us and I will be forwarding a background memorandum on this topic shortly.

B. Medicaid

We won an important victory by preserving Medicaid and its Federal guarantee of eligibility for 37 million poor, disabled, and elderly Americans. The balanced budget plan included \$54 billion in Medicaid savings. As we develop a revised budget plan, it is important to note that Medicaid's baseline has already been reduced by \$46 billion since the presentation of the current budget.

At the same time, we must continue to vigorously pursue ways to make Medicaid more flexible for the states while maintaining national standards and equity through our important oversight responsibility. We have already expanded the number of beneficiaries in managed care by 140% over the past three years. And our 15 waivers are promoting innovation--including new approaches to managing chronic illnesses.

Protecting the Health and Safety of Children

Working with parents, schools, health professionals, and others we have vastly improved the chances of a child born in America today living a long and productive life. Increased prenatal care and immunization rates mean a generation of healthier children who will grow up to be healthier adults. With relatively modest investments, we can continue to extend the length and quality of people's lives by:

A. Expanding Health Coverage of Children

Nearly 10 million children -- one in seven -- are uninsured in America today. That number has been increasing as employers have been reducing dependent coverage. Our goal must be to incrementally reduce this number to zero. While some in Congress are proposing large-scale government subsidies, I believe this issue requires a multi-faceted strategy that involves a more pragmatic series of incremental steps by both Federal and State government as well as private employers. These steps include:

- Under current law, we will add an estimated 1 million children to Medicaid over the next four years under the scheduled phase-in of adolescents in families below the Federal poverty line. One option would be to encourage states to move more quickly -- perhaps by 1998.
- An estimated 3 million children currently are entitled to Medicaid coverage but are not enrolled. Working with the states we should seek to identify and enroll these children and, in many cases, their parents. This is particularly important as it relates to implementation of welfare reform.
- Most of the remaining uninsured children -- known as "Gap Kids" -- fall between Medicaid eligibility and private coverage from their parents' employers. We will work with the States to develop models appropriate to their circumstances. Pennsylvania has been a leader in this area, developing a strong public-private partnership that makes private coverage for children affordable for their parents.

- Finally, we will maximize our growing investment in community health centers, which can be a tremendous resource of care for uninsured children and working families. By building and supporting primary care capacity in under-served communities we could help states provide coverage and services to many uninsured children.

B. Providing A Safe and Healthy Environment for Children

While we build a stronger insurance safety net for our children, we also must continue our work to protect the physical health and safety of those kids. Initiatives include:

- **Tobacco and Kids.** We are poised to implement your anti-tobacco policies. Keeping one million kids from smoking will reduce our medical bill by \$12 billion.
- **Reducing Drug Use.** Drug use among young people is on the rise and more than 10 million people under 21 are now consuming alcohol. Aggressively reducing these rates will save countless lives.
- **Vaccinating Children.** Today we have record high immunization coverage of two year olds (approximately 76%), and record low incidence of vaccine preventable disease in children. We must continue to build on that success and work to increase our immunization coverage to 90% by the end of the century.
- **Infant Mortality.** We have seen a sharp decline in infant deaths -- down one-third since you took office -- thanks to increased prenatal care and the remarkable reduction in sudden infant death syndrome due to the "Back to Sleep" campaign that advises mothers to place their infants on their backs while they sleep. We are virtually certain to reach our current goal of further reducing the infant mortality rate by the year 2000.

Protecting the Health of Working Families

The number of uninsured Americans has grown slightly during the first term to approximately 40 million and an estimated 80% of those individuals are either workers or the dependents of workers. We can systematically seek to reduce this number in incremental steps without a major impact on the Federal budget. The steps follow naturally on the Kennedy-Kassebaum law, which provides protection for workers who have insurance and those who are self-employed and buy their own coverage. Initiatives include:

- **Workers Between Jobs.** As included in the balanced budget plan, we would provide states with funds to subsidize the purchase of insurance for up to six months for workers who are receiving unemployment compensation and who had employer-sponsored coverage while they were working. This is the logical next step to Kennedy-Kassebaum and would assist 3.1 million uninsured individuals a year including up to 700,000 children.
- **Medicaid Waivers.** By allowing for extension of the statewide Medicaid waivers, we would ensure the continuation of coverage for those who received insurance under these waivers.
- **Medicaid Buy-In Options.** States would be encouraged to extend coverage to working Americans by charging an income-related premium to buy into Medicaid. This has been a popular option among the waiver states.
- **Voluntary Insurance Cooperatives.** The balanced budget plan also includes grants totaling \$25 million a year to assist in the creation of voluntary health insurance purchasing cooperatives as a means for small employers to negotiate lower prices for coverage for their workers.

Providing for Consumer Protections, Quality, and a Safe America

Our health initiatives must address the needs of all Americans for consumer protections and quality for themselves and their families in the health system, as well as public health measures to assure a safe, and healthier America.

A. Consumer Protection and Quality Assurance.

The new Advisory Commission on Consumer Protection and Quality in the Health Care Industry will develop options to protect consumers' rights and the quality of care delivered in our rapidly changing health care system.

B. Safer America

Disease prevention efforts have contributed to 70% of the gains in U.S. life expectancy since the turn of the century. In fact, the majority of premature death and preventable disability is directly related to behavior. In the last four years, we have made remarkable progress in improving the health and safety of the American people. Through investments in public health we have saved the lives of countless men, women, and children. We will continue this progress in the following areas:

- **Food Safety.** A Presidential food safety initiative will improve our surveillance of food-borne disease; strengthen our system of inspections; expand the use of preventive controls used for seafood, meat, and poultry to other high-risk food products; increase our research base in microbiological risk assessment; improve coordination among local, state, and Federal health and regulatory authorities; and boost public education in the handling of food.
- **Injury Prevention.** Unintentional injuries account for 150,000 deaths among children, youth, and young adults. We can prevent many injuries through things like bike helmets, safety seats, sobriety checks, and safe work stations.
- **Violence Prevention.** By fully implementing the Violence Against Women Act we can provide a safe refuge for battered women and their children and help prevent a leading cause of injuries in women. A model program to reduce youth violence

through the schools and community-based organizations will include a non-violence curriculum for students, a parenting education program for adults, and an after-school program.

- **HIV Prevention and Treatment.** While the number of new infections with HIV has declined sharply from the rates experienced in the 1980s (from 100,000 per year to 40,000 per year), there has been little progress made in the last five years. Increased funding of CDC's HIV prevention activities allows us to focus on high-risk populations -- youth, women, and substance abusers. In addition, HHS-funded and sponsored research into HIV treatment alternatives has led to a number of promising drug therapies. We will continue to support focused research on HIV treatment.

THE WHITE HOUSE
OFFICE OF DOMESTIC POLICY

CAROL H. RASCO
Assistant to the President for Domestic Policy

To: _____

Draft response for POTUS
and forward to CHR by: _____

Draft response for CHR by: _____

Please reply directly to the writer
(copy to CHR) by: _____

Please advise by: _____

Let's discuss: _____

For your information: _____

Reply using form code: _____

File: _____

Send copy to (original to CHR): _____

Schedule ? :

☐ Accept

☐ Pending

☐ Regret

Designee to attend: _____

Remarks: _____



THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, DC 20201

TO: All Staff
FROM: The Secretary
DATE: February 21, 1996
SUBJECT: New Role for the Assistant Secretary for Health

As you know, pursuant to our Reinvention of Government and streamlining processes, I have merged the Office of the Assistant Secretary for Health (OASH) with the Office of the Secretary, (OS), creating a unified corporate headquarters for the Department that brings expertise in public health and science closer to the Secretary.

The merger creates a new role for the Assistant Secretary for Health (ASH), who becomes head of the Office of Public Health and Science (OPHS), a new division within OS. The Public Health Service (PHS) agencies become HHS Operating Divisions, reporting directly to the Secretary. These Operating Divisions, along with the new OPHS, continue to constitute the U.S. Public Health Service, with the Secretary of Health and Human Services as its head.

The ASH will have a distinctive role within the OS, leading an office defined by a substantive area rather than by a function. The ASH will, by necessity, have a "hybrid" role, acting as senior advisor for public health and science to the Secretary and providing senior professional leadership in the Department on population-based public health and clinical preventive services. In addition, the ASH will exercise certain operational responsibilities under my direction by: directing program offices within the OPHS; providing professional leadership on cross-cutting Departmental public health and science initiatives; and, at the direction of the Secretary, providing assistance in managing the implementation of Secretarial decisions for the Public Health Service Operating Divisions. To perform this role the ASH will:

1. Function as the Secretary's senior advisor for public health and science by:

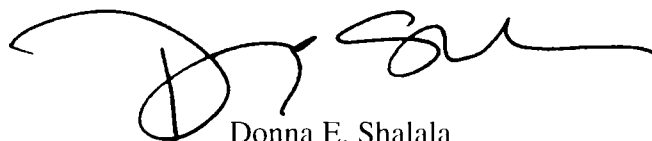
- serving as the senior professional representative to the public health and science communities;
- serving as the senior professional representative on public health and science related interagency and interdepartmental task forces and as the liaison with the White House Office of Science and Technology Policy;
- serving as the senior professional spokesperson on public health and science issues;
- providing advice to the Secretary in the review of budget and legislative proposals related to public health and science;
- assisting the Secretary in developing a policy agenda for the Department to address major population-based public health, prevention and science issues; and,
- fulfilling emergency preparedness leadership responsibilities in health.

2. Provide leadership and, as directed by the Secretary, serve as the focal point for coordination across the Department in public health and science by:
 - assuring that the Department conducts broad-based public health assessments designed to anticipate future public health issues and problems and to assure that the Department devises and implements appropriate interventions and evaluations to maintain, sustain and improve the health of the Nation;
 - providing assistance in leading and managing the implementation and coordination of Secretarial decisions for PHS operating divisions, and, for that purpose, drawing on staff divisions and other units for assistance in regard to legislation, budget, communications, and policy analysis;
 - providing leadership and a focus for coordination of population-based health, clinical preventive services and science initiatives that cut across operating divisions;
 - providing leadership for and management of the OPHS that will consist of the following OS offices:
 - Office on Women's Health
 - Office of Minority Health
 - Office of Emergency Preparedness
 - Office of Population Affairs
 - Office of International and Refugee Health
 - Office of Disease Prevention and Health Promotion
 - President's Council on Physical Fitness and Sports
 - Office of Research Integrity
 - Office of HIV/AIDS Policy
 - Office of the Surgeon General

providing leadership and coordination with the Office of International Affairs on international health issues and representation to foreign governments and multilateral agencies on health issues.
3. Through the Surgeon General, provide direction of and policy setting oversight for the Commissioned Corps as well as providing the organizational base for the Surgeon General's exercise of statutory and assigned responsibilities.
4. Assure that the PHS mission is carried out in concert with the Department's overall mission by chairing the new Public Health Council.

I have asked Dr. Lee to develop a charter for the Council that will allow it to serve as a forum for coordinating the leadership of the new Public Health Service and other components of the Department, as appropriate, to advise me on cross-cutting public health issues and activities.

This is a time of major change in the management of the Department and of the Nation's health sector. I am aware that, as with any new organizational arrangement, questions and issues arise because of the unanticipated effects of change. I know that everyone will work to resolve any problems in a collaborative manner. I am committed to strengthening public health and science programs in the Department and believe that the reinvented organization and the new responsibilities of the ASH are essential to achieving that end.



Donna E. Shalala



DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

JUN 20 1996

Assistant Secretary for Health
Office of Public Health and Science
Washington, D.C. 20201

Dear Colleague:

Several important changes have recently taken place in the organization of the Department and the U.S. Public Health Service (PHS) that will strengthen the Department's ability to provide leadership in public health and science.

As a part of the Administration's Reinvention of Government (REGO) efforts, the roles and responsibilities of the Office of the Assistant Secretary for Health (OASH) have been reorganized. The personnel, finance, and administrative management functions of OASH were either reorganized into a newly established Program Support Center that will serve the entire Department, or were transferred to the operating divisions. The professional public health and science functions and cross-cutting program offices were organized into a new division in the Office of the Secretary (OS), the Office of Public Health and Science (OPHS), headed by the Assistant Secretary for Health (ASH).

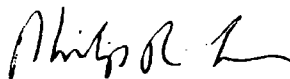
At the same time, the agencies of the Public Health Service that had reported to the ASH were elevated to operating division status with management lines reporting directly to the Secretary. Agency heads were given additional and broader delegations of authority providing them with new tools with which to manage their responsibilities.

The final element of the reorganization involves a new management and representational structure for public health at the regional level. The Regional Health Administrators (RHAs) have become integral members of the Office of the Regional Director, HHS, in each region. The RHAs will continue to supervise the regional activities of the minority health and women's health coordinators, the Office of Population Affairs, and the Office of Emergency Preparedness, and will remain the chief federal public health official for their respective region. The RHAs will maintain a "dotted line" relationship with the OPHS and the ASH for the purposes of professional public health coordination and consultation. The new operating divisions, the Regional Health Administrators, and the OPHS, which includes the Office of the Surgeon General, continue to constitute the PHS.

To assure close cooperation and collaboration among health agencies, a Public Health Council has been established under the direction of the Secretary and chaired by the ASH. The Council consists of the agency heads of PHS operating divisions, as well as members from the Office of the Assistant Secretary for Management and Budget, the Office of the Assistant Secretary for Planning and Evaluation, the Health Care Financing Administration, and representation from the Administration for Children and Families and all of the OPHS staff offices.

These changes free the ASH from day-to-day management responsibilities to allow for a focus on policy and program and be in a stronger position to serve the critical role of the Department's senior professional representative to the public health and science communities. The ASH will continue to be the senior public health and science advisor to the Secretary, provide senior professional leadership in the Department on population-based public health, direct the program offices within the OPHS and, at the Secretary's request, provide assistance in managing the implementation of Secretarial decisions relating to cross-cutting issues involving the PHS Operating Divisions.

A copy of the Secretary's memorandum announcing the new role of the ASH is reproduced in this issue. It provides more detail on the new organization and role of the ASH.

A handwritten signature in black ink, appearing to read "Philip R. Lee". The signature is fluid and cursive, with a long horizontal stroke at the end.

Philip R. Lee, M.D.
Assistant Secretary for Health



PROGRESS REPORT FOR: Occupational Safety and Health

On March 9, 1995, the Public Health Service (PHS) conducted a review of progress on HEALTHY PEOPLE 2000 objectives for occupational safety and health. The lead agency for this priority area is the Centers for Disease Control and Prevention. Representatives of the Health Resources and Services Administration and the National Institutes of Health were joined for the review by representatives from Organization Resources Counselors, Inc.; California Medical Center; New York State Department of Health; the University of Iowa College of Medicine; and the AFL/CIO. Other Federal participants included staff from the Departments of Labor and Energy, and the Environmental Protection Agency.

The Director of the National Institute for Occupational Safety and Health (NIOSH) began by emphasizing that occupational injury and disease cause needless human suffering, burden health care resources, and drain U.S. productivity. In 1994, employers reported 6.3 million disabling work injuries and 514,700 cases of occupational illnesses. In that year, an average of 18 American workers died each day from injuries on the job. An average of 137 workers died each day from workplace diseases. In 1994, work injuries cost \$121 billion in medical care, lost productivity, and wages. Medical payments under workers' compensation rose to almost \$17 billion in 1991 with a total of more than \$40 billion paid in workers' compensation claims.

The number of fatal occupational injuries in the United States has been declining. For 1994, the Bureau of Labor Statistics reported 5 deaths from work-related injuries per 100,000 full-time workers. The 1983-87 baseline was 6 per 100,000. Mortality rates in mining (including oil and gas extraction), construction, transportation, communication, public utilities, agriculture, forestry, and fishing are consistently higher than in all other industries. Rates decreased in nearly every demographic and employment sector, with greater declines among men, African Americans, and younger workers.

National Traumatic Occupational Fatality (NTOF) data show that homicide is the third leading cause of traumatic occupational fatalities and that convenience store workers and taxicab drivers are among those employed in the highest risk occupations. Because of these findings, a new objective is included in *Healthy People 2000 Midcourse Review and 1995 Revisions* to reduce deaths from work-related homicides to no more than 0.5 per 100,000 full-time workers from an average of 0.7 per 100,000 during 1980-89.

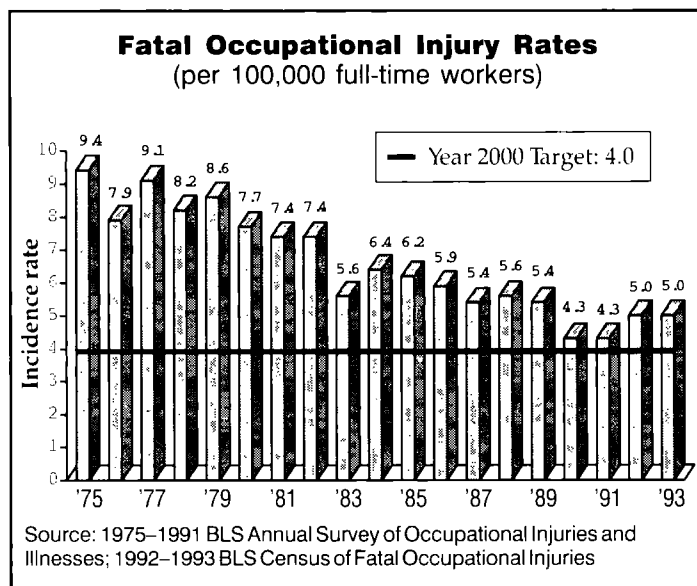
Rates of work-related nonfatal injuries have increased during the past 6 years. Compared with the baseline of 7.7 injuries per 100 full-time workers (an average for the years 1983-87), there were 8.4 cases in 1994. Risks to construction and mine workers have decreased while on-the-job injury

increased among nursing and personal care workers. It is possible that part of this increase is due to greater awareness and reporting of injuries such as needle sticks.

A NIOSH study shows that each year 22,000 youths are injured or develop work-related illnesses, and 64,000 are treated in emergency rooms. About 70 youths suffer fatal occupational injuries each year. A new HEALTHY PEOPLE 2000 special population target is to reduce injury rates among adolescent workers to 3.8 per 100 from a baseline of 5.8 per 100 in 1992.

New cases of cumulative trauma disorders have increased from 100 cases per 100,000 workers in 1987 to a high of 383 cases per 100,000 workers in 1993. Disorders resulting from repeated motion, noise-induced hearing loss, and vibration injuries are included, but lower back disorders are not. Increases in reported cumulative trauma disorders may be due to heightened awareness and better reporting, but also to changes in work design, such as increased automation and job specialization, both of which increase the amount of repetition performed by the worker.

Occupant protection reduces injury in automobile crashes. Data from 1980-89 indicate that the leading cause of worker fatality was trauma sustained in motor vehicle crashes (23 percent), ranking ahead of machine-related incidents (14 percent), homicides (12 percent), falls (10 percent), electrocutions (7 percent), and falling objects (7 percent). The 1992 *National Survey of Worksites Health Promotion Activities* indicated that 82 percent of all worksites with 50 or more



Occupational Injury and Disease Burden

Every day

- ☛ 900 workers sustain disabling injuries on the job
- ☛ 17 workers die from work-related injuries
- ☛ 137 workers die from work-related diseases

In 1994, work injuries alone cost \$121 billion in medical expenses and lost productivity and wages.

Source: Bureau of Labor Statistics, NIOSH Traumatic Occupational Fatalities Surveillance System, National Safety Council

employees require use of occupant protection. Hence, the year 2000 target was increased from 75 percent to 95 percent.

Depending on data sources, there has been little change over the past 20 years in the rate of employees who are exposed to damaging levels of noise. Between 1989 and 1993, the U.S. Air Force Hearing Conservation Database indicates an increase from 16 to nearly 20 percent of workers exposed to average noise levels above 85 decibels. Comprehensive noise and hearing data are currently being analyzed by the U.S. Army and the United Auto Workers.

In 1994, 12,137 individuals were reported with blood lead levels greater than 25 micrograms/deciliter. This lead exposure was attributed to the workplace and represents a 7 percent increase over 1993. This increase could be the result of adding two States, North Carolina and Oklahoma, to the surveillance system (bringing the number of States to 23), or it could be a reporting artifact representing increased awareness and consequent improved reporting. When extrapolated to the entire United States, this suggests there are as many as 30,000 individuals with blood lead levels in that range. The incidence of hepatitis B is decreasing; immunizations among occupationally exposed workers are increasing.

Federal standards were established in 1969 and 1970 for occupational exposure to airborne asbestos fibers (which cause asbestosis), cotton dust (which causes byssinosis), coal mine dust (which causes coal workers' pneumoconiosis), and silica dust (which causes silicosis). Because these standards apply to all 50 States and U.S. Territories, this objective is considered to be accomplished. A new objective for tracking mortality from occupational exposures has been added.

According to the Worksite Health Promotion Survey, 63.8 percent of worksites provide education on job hazards and injury prevention. The occupational safety and health programs covered most often at worksites included lifting/back injury (54 percent), machinery/equipment hazard (37 percent), and general risk/safety management (30 percent). Despite numerous studies to identify the causes of back injury over the last decade, little is known of the etiology of low back pain. In the majority of back pain complaints, no specific, verifiable pathology can be identified with current clinical methods. The inability to clearly identify and understand the risk factors for low back pain hampers prevention efforts and the ability to minimize disability. The worksite survey indicates that 32.5 percent of worksites offer prevention and rehabilitation programs.

Follow-up items from the progress review fall into the three general areas of surveillance, services and communication. CDC was asked to suggest ways to improve surveillance systems to detect and monitor emerging problems such as workplace violence and homicide, safety and health of working children, and occupational asthma. The Health Care Financing Administration claims data could be used to track injuries and improve occupational safety and health surveillance. Collaboration among HHS laboratories and those of other departments should be initiated. CDC should also develop a plan for new epidemiologic research strategies to assess and confront new occupational safety and health issues specific to the evolving service sector economy.

To enhance occupational health services, we also need to address the national shortage of occupational health clinicians and integrate occupational health clinical practices with primary health care and managed care. The Agency for Health Care Policy and Research should assess the potential for clinical practice guidelines or protocols to assist primary care providers in assessing occupational health effects. IHS and HRSA-funded clinics should be staffed and equipped to do occupational health assessments.

As for communication strategies, there is a need for publicizing more effectively such success stories as the beneficial impact of regulations and guidelines on occupational safety and health. Finally, joint partnership opportunities with State, Tribal and local governmental entities, private sector businesses, unions and medical professionals should be identified for information sharing and dissemination.

Public Health Service Agencies

Agency for Health Care Policy and Research
Agency for Toxic Substances and Disease Registry
Centers for Disease Control and Prevention
Food and Drug Administration
Health Resources and Services Administration
Indian Health Service
National Institutes of Health
Substance Abuse and Mental Health
Services Administration
Office of the Surgeon General

HEALTHY PEOPLE 2000 Coordinator

Office of Disease Prevention and Health Promotion
Humphrey Building, Room 738G
200 Independence Avenue SW.
Washington, DC 20201
202-205-8611
FAX: 202-690-7054



Philip R. Lee, M.D.
Assistant Secretary for Health



CONSORTIUM EXCHANGE

National Public Health Week 1996

Donna E. Shalala, Secretary of the Department of Health and Human Services, kicked off National Public Health Week on April 1 at the Centers for Disease Control and Prevention's (CDC) 50th anniversary ceremony in Atlanta, Georgia. The theme of this second annual event was "Celebrating Success." President Clinton established National Public Health Week in 1995 as a way of recognizing the contributions of public health and prevention services to America's well-being.

Secretary Shalala commended CDC for its first 50 years of promoting public health and for continued vigilance in preventing disease and disability throughout the world. The Secretary offered five challenges to help write the next chapter in public health history. These challenges include staying hot on the trail of infectious diseases; teaching Americans healthy behaviors and the value of preventive services, such as immunizations and breast cancer screening; creating healthy communities by guaranteeing healthy environments; and preventing injuries by making America's homes and neighborhoods safe. The final challenge is tapping into the power of communication to give people the information they need to be the guardians of their own health. This means

finding new communication strategies to reach all Americans—especially young Americans in their homes, schools, and offices.

In addition to the kick-off in Atlanta, this year's events included a rally at the Dorothy Chandler Pavilion in Los Angeles, California, attended by several thousand public health workers and a celebration in Arlington, Virginia, where the acting Surgeon General, Dr. Audrey Manley, issued a proclamation. Other States and localities also honored the occasion. North Carolina's events were month-long, with the State health department providing 100 counties with information packets and posters to help them celebrate public health in their communities. For more information about Public Health Week 1997, call Katherine McCarter at (202) 789-5651.

A Challenge for Rhode Island Employers

The Rhode Island Department of Health has initiated the Healthy Rhode Islanders Challenge, a program to provide employers in the public and private sectors with specific strategies they can use to improve the health and well-being of employees in the workplace. The Worksite Challenge Book translates the State's year 2000 health objectives into concrete suggestions to promote improved health. It offers a

wide range of activities for organizations to use with their customers and the community. Information about Rhode Island companies that have initiated similar programs and are willing to serve as mentors or share their experiences also is available. The Department of Health offers technical assistance in identifying appropriate activities based on a company's interests and resources. All participating companies will receive public acknowledgment. The Challenge program is sponsored in part by CDC. For more information, call Mary Lou DeCiantis at (401) 277-2588.

ABOUT CONSORTIUM EXCHANGE

Healthy People 2000 CONSORTIUM EXCHANGE is a new information resource for Healthy People 2000 Consortium members to share news about prevention activities related to achieving one or more of the Nation's health promotion and disease prevention objectives. Please send news about your programs and activities to Ellis Davis, Office of Disease Prevention and Health Promotion, 200 Independence Avenue S.W., Room 738G, Washington, D.C. 20201; (202) 260-2873. Fax (202) 205-9478. Healthy People 2000 Homepage — <http://odphp.osophs.dhhs.gov/pubs/hp2000>

Healthy People 2000 is a national initiative to improve the health of all Americans through prevention. It is driven by 300 specific national health promotion and disease prevention objectives targeted for achievement by the year 2000. Healthy People 2000's overall goals are to: increase the span of healthy life for Americans, reduce health disparities among Americans, and achieve access to preventive services for all Americans.

Immunize for Healthy Lives

The National Association of County and City Health Officials (NACCHO) is teaming up for the third consecutive year with McDonald's and the American Academy of Pediatrics on "Immunize for Healthy Lives," a national immunization education campaign for parents. The program helps local health departments reinforce the need for timely immunizations and encourages parents to have their children vaccinated. "Immunize for Healthy Lives" reached over 65 million people in 1995 as more than 300 local health departments collaborated with over 5,800 McDonald's restaurants. Educational materials, including trayliners and leaflets, are used in participating McDonald's restaurants. Also, major publicity campaigns are conducted. Last year, extensive news coverage highlighted hundreds of local "Immunize for Healthy Lives" programs around the country. Local health officials are building on the successes of last year through continued partnerships with McDonald's restaurants and pediatricians. The month of August, before school begins, is a key time to start this program. To get involved, call Sarah Schenck at (202)783-5550.

Examining Attitudes Toward Depression

As part of its ongoing efforts to educate Americans about clinical depression, the National Mental Health Association (NMHA) released findings from an in-depth survey of 1,166 adults on attitudes toward, and barriers to, seeking treatment for clinical depression. Oversampling was conducted among women, African-Americans, and older adults to gauge their attitudes and awareness of this illness, which affects an estimated 17 million people each year. Among the key findings were that less than one-third of respondents are aware of

the symptoms associated with depression, such as anxiety, agitation, and reductions in sleep and eating. Almost half of the respondents believe that clinical depression is a normal part of aging, rather than a treatable illness, and one third of survey respondents cite lack of insurance or money as a barrier to treatment. If suffering from depression, 54 percent said they would seek help from someone other than a health professional and one in four would handle it themselves. "Knowing what people believe are the obstacles to treatment—whether perceived or real—can assist us in reaching out to them and helping them break out of the box of clinical depression," said Mike Faenza, President of the National Mental Health Association. For more information, call Karen Waller at (202) 530-4607, or Colleen Reilly at (703) 838-7516.

Healthy Families America

Healthy Families America (HFA), is an initiative of the National Committee to Prevent Child Abuse (NCPCA), in partnership with Ronald McDonald House Charities (RMHC). It promotes voluntary home visiting for new parents to ensure that all new parents, particularly those facing the greatest challenges, receive the education and support they need at the time their baby is born and in the subsequent months. The provision of home visiting services has been shown to improve birth outcomes and prevent child abuse and neglect. NCPCA is collaborating with many other national partners to facilitate part-

nerships among State and local affiliates to support, implement, and institutionalize home visitation services for new parents. The goal is to ensure that all States have a multi-disciplinary task force composed of public and private agency representatives working to institutionalize Healthy Families at the State level.

Currently, 192 sites are operating in 31 States and the District of Columbia. The program adheres to a set of critical elements: family support plans are developed between the parents and home visitor; services focus on supporting the parent as well as supporting parent-child interaction and child development; families are assessed prenatally or at the time of birth to identify those in need of services; enrollment is voluntary; visits begin weekly and gradually progress to bimonthly, monthly, and quarterly, with families remaining in the program for up to five years; parents learn parenting and life skills; families are linked to other community services; and an evaluation component measures outcomes such as immunization rates, age appropriate development, and reports of child abuse and neglect. The program allows home visitors to tailor services by building upon parents' strengths to identify and address their areas of concern. For more information about the initiative, call Anna Loftus at (312) 663-3520.





PROGRESS REVIEW

Unintentional Injuries

DEPARTMENT OF HEALTH & HUMAN SERVICES ■ PUBLIC HEALTH SERVICE ■ January 23, 1996

In a review of progress on HEALTHY PEOPLE 2000 objectives for unintentional injuries, the Centers for Disease Control and Prevention, lead agency for this priority area, provided an update on the status of 10 selected objectives:

9.1 Between 1987 and 1994, the death rate for unintentional injuries decreased by 14 percent. The year 2000 target of 29.3 per 100,000 people has nearly been reached. However, unintentional injuries continue to be the leading cause of death among children and young adults aged 1-34.

9.2 Hospitalizations for nonfatal unintentional injuries dropped to 699 per 100,000 people in 1993, below the year 2000 target of 754. There are difficulties in monitoring this objective because less than half of hospital discharges include e-codes, a code for the external cause of the injury.

Only 15 States currently mandate the use of e-codes in their hospital discharge systems. Hence, tabulation of the data on injuries must rely on information that does not distinguish intentional and unintentional injuries. Increasing the use of e-codes in hospital discharge systems will improve tracking of this objective.

9.3 Because this objective was achieved early in the decade, the target was revised during the midcourse review. Although motor vehicle-related deaths have decreased from 2.4 per million miles traveled in 1987 to 1.7 in 1994 (target=1.5), and from 19.2 per 100,000 people in 1987 to 15.6 in 1994 (target=14.2), motor vehicle-related deaths among young children and the elderly have increased.

9.4 The death rate from falls and fall-related injuries has declined from 2.7 per 100,000 in 1987 to 2.5 in 1993; the year 2000 target is 2.3 per 100,000. In 1992, falls were the second leading cause of unintentional injury deaths for people aged 65 to 84 years. Effective interventions for older people include the identification of physical activities appropriate for their age, improved prescribing practices to minimize the effects of polypharmacy, and changes to building design and flooring materials.

9.5 The death rate from drowning declined from 2.1 per 100,000 in 1987 to 1.7 in 1993; the year 2000 target is 1.3. Drowning is the third leading cause of unintentional injury deaths for children aged 1 to 4. Interventions that have proven effective include water safety training, adoption of laws requiring four-sided isolation pool fencing, use of personal flotation devices while boating, and efforts to increase public awareness about risks associated with alcohol use while swimming or boating.

9.6 The decline in residential fire death rates (from 1.7 per 100,000 in 1987 to 1.4 in 1992) is approaching the year 2000 target (1.2 per 100,000). Some 3,600 people died in 1992, and there were over 27,000 injuries from residential fires; children and the elderly are at greatest risk. On average, one out of every 200 households experiences a fire each year, and the rate is greater among poor households. Smoke detectors and sprinklers have proven to be effective interventions in reducing the incidence of residential fire deaths.

9.7 The trend in hospitalizations for hip fractures among people aged 65 and older is moving away from the year 2000 target. Hospitalizations increased from 714 per 100,000 people in 1988 to 841 in 1993; the year 2000 target is 607. This increase reflects an international trend. Hip fractures are a cause of severe disability in the elderly, half of whom never return to independent living after

suffering such an injury. Elderly white women may be at greater risk because of greater susceptibility to osteoporosis. Recent research found that a person must fall directly on the hip in order to break the hip, which suggests that padding the hip joint of an elderly person would reduce the incidence of hip fractures. This strategy is currently being evaluated.

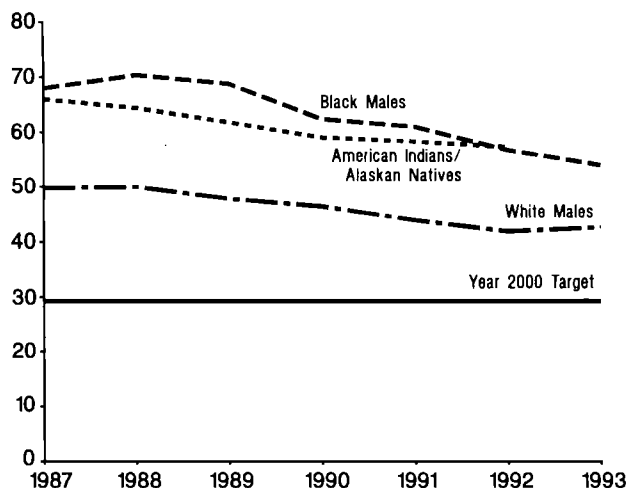
9.8 Nonfatal poisonings requiring hospital emergency department admissions declined substantially from 1987 to 1994 (from

HIGHLIGHTS

- The Department of Transportation's National Highway Traffic Safety Administration can take a measure of credit for the reduction in highway fatalities through a variety of intervention programs that increase the use of safety belts, child restraints, and motorcycle helmets, and reduce the incidence of drinking and driving.
- Fire exacts tremendous costs to the Nation, accounting for the loss of one person every 2 hours, including the deaths of 100 firefighters and 123,000 injuries on average per year, and \$8 billion per year in property losses.
- The National Fire Protection Association's "Learn Not to Burn" instructional program is being distributed to Indiana schools by the State Fire Marshall's Office. Indiana hopes to be the first State in the United States to have a statewide program; it is currently being taught in every school in Canada.
- The Oklahoma State Department of Health distributed free smoke detectors in a community with a high incidence of fire-related injuries and found a 73 percent reduction in injuries 4 years later in that community. Each dollar spent on fire prevention saved \$20.

Unintentional Injuries per 100,000

1987 - 1993



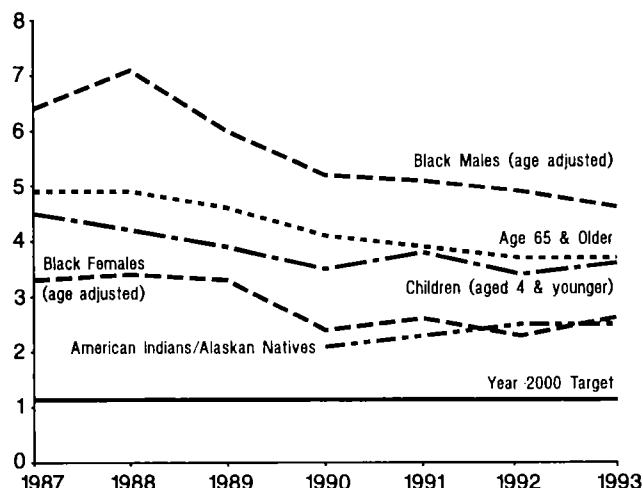
Source: National Vital Statistics System

87 per 100,000 people to 49), so that the year 2000 target of 88 for the general population has been achieved. This decline is partly due to a change in the reporting system. However, reformulation of products, better packaging, and poison control centers have helped spur this reduction in poisoning incidence. Poisonings in children aged 4 and younger also surpassed the year 2000 target (520 per 100,000) by dropping 32 percent from the new 1987 baseline of 762 to 518 in 1994.

9.13 Data for 1991 show that helmet use among motorcyclists was 62 percent (the year 2000 target is 80 percent) and among

Residential Fire Deaths per 100,000

1987 - 1992



Source: National Hospital Discharge Survey

bicyclists was 17.6 percent, far short of the year 2000 target of 50 percent. The target for motorcyclists is unlikely to be met, in view of the trend toward repeal of State mandatory use laws. In States having such laws, the usage rate is 90 percent; in those without, it is 30 percent.

9.26 This objective was added during the midcourse review as a strategy to reduce the number of injuries and fatalities involving drivers 18 years of age and younger. To date, only 16 States have some type of graduated licensing system in place (the target is 35 States).

FOLLOW-UP

- Increase the public's awareness of the costs and avoidable nature of unintentional injuries.
- Use States as laboratories for innovative injury prevention programs, then document and publicize the successes.
- Monitor unintentional injury rates as highway speed limits and motorcycle helmet laws are repealed.
- Pursue collaborations with other prevention programs to conduct home safety assessments when conducting home visits.
- Promote use of uniform e-codes for hospital discharge in all States.
- Collaborate with the National Committee on Quality Assurance to identify HEDIS (Health Plan Employer Data and Information Set) measures to monitor the impact of unintentional injuries.
- Assess differences in hospitalization rates for nonfatal injuries between managed care and other payment methods.

PARTICIPANTS

Centers for Disease Control and Prevention (Lead Agency)
 Administration for Children and Families
 Administration on Aging
 Advocates for Highway and Auto Safety
 Consumer Product Safety Commission
 Health Resources and Services Administration
 Indian Health Service
 Indiana Department of Fire and Building Services
 National Association of Children's Hospitals and Related Institutions
 National Association of County and City Health Officials
 National Fire Protection Association
 National Highway Traffic Safety Administration
 National Institutes of Health
 National SAFE KIDS Campaign
 National Safety Council
 Office of Disease Prevention and Health Promotion
 Office of Public Health and Science
 Office of the Surgeon General
 Oklahoma State Department of Health
 State and Territorial Injury Prevention Directors Association
 Substance Abuse and Mental Health Services Administration



Philip R. Lee

Philip R. Lee, M.D.
 Assistant Secretary for Health

Clinton Presidential Records Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a publication.

Publications have not been scanned in their entirety for the purpose of digitization. To see the full publication please search online or visit the Clinton Presidential Library's Research Room.

PREVENTION *report*

U.S. Department of Health and Human Services

Spring/Summer 1996

To Russia With Health: Internet Aids Globalization of Public Health

The democratization of Russia has led to an extraordinary teaming of Russian and U.S. officials to improve the lives of citizens in both nations. Created by President Clinton and Russian President Yeltsin after their 1993 summit meeting, the U.S.-Russia Joint Commission on Economic and Technological Cooperation (JCETC) advances bilateral cooperation on many global issues, including health.

Also known as the Gore-Chernomyrdin Commission for the cochairs, Vice President Al Gore and Prime Minister Victor Chernomyrdin, the commission conducts its work through eight committees on health, space, business and investment development, energy, defense conversion, science and technology, environment, and agriculture. Numerous cooperative ventures and programs have resulted, many supported by technology, especially the information superhighway.

Directing the globalization of public health is the Health Committee co-chaired by Secretary of Health and Human Services Donna E. Shalala and A.D. Tsaregorodtsev, Minister of Health and Medical Industry of the Russian Federation. A key vehicle in the committee's exchange of information for improving health of citizens in both countries is the Internet. Indeed, the committee has a World Wide Web site (<http://odphp.osophs.dhhs.gov/russia>) with text in both English and Russian.¹

The Health Committee, which has met four times since its formation in late 1994, seeks to have a practical impact on the health status of both Americans and Russians through cooperative activities. The primary tool for achieving this goal is the exchange of information using all types of communication vehicles. This includes the Internet and e-mail as well as traditional printed materials, exchange visits, and face-to-face technical assistance. Collaborations and discussions among government officials and scientists, training, and public-private partnerships are also being pursued.

Indeed, one of the most far-reaching achievements to date has been U.S.-Russian and public-private cooperation. This cooperation is seen within agency departments, across agencies, and between governments and industry at the local, State, and national levels. Members also work with other committees, particularly those concerning business development and the environment.

The Health Committee has identified eight priority areas—diabetes, health education and promotion, prevention and

(continued on page 2)

¹ By its very existence, the committee helps promote the benefits of international networked health information, the topic of the previous issue of *Prevention Report*. For an online version, see the National Health Information Center's World Wide Web site: <http://nhic-nt.health.org/>. For transcripts of the recently conducted 1996 Partnerships for Networked Consumer Health Information conference, see this World Wide Web site: <http://odphp.osophs.dhhs.gov/confnce/partnr96/>.

What's Inside

Committee Actions	3
Spotlight	5
In the Literature	6
Activities	10
Meetings	10
Etcetera	12



EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
LEGISLATIVE AFFAIRS

PHONE: 395-4790 / FAX: 395-3729

PLEASE DELIVER IMMEDIATELY TO:

LEON PANETTA	456-1121
LAURA TYSON	456-2878
ROBERT RUBIN	622-0073
GEORGE STEPHANOPOULOS	456-6703
JOHN HILLEY	456-6220
CAROL RASCO	456-2878
JEREMY BEN-AMI	456-7431
KITTY HIGGINS	456-6704
RON KLAIN	456-6212
DON BAER	456-1213
MIKE McCURRY	456-6423
JOE STIGLITZ	395-6958
ALICIA MUNNELL	395-6947
MARTIN BAILY	395-6958
GENE SPERLING	456-2878
MARTHA FOLEY	456-2271
DAN TARULLO	456-1605
BARBARA CHOW	456-2604
JANET MURGUIA	456-2604
BEN NYE	622-0073

CC: ELI Z

PIANA

MIKE

PATSY

DENNIS

NUMBER OF PAGES: 14 (Includes cover)



EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

September 10, 1996

The Honorable Robert C. Byrd
Committee on Appropriations
United States Senate
Washington, D.C. 20510

Dear Senator Byrd:

The purpose of this letter is to provide the Administration's views on H.R. 3755, the Departments of Labor, Health and Human Services, Education, and Related Agencies Appropriations Bill, FY 1997, as passed by the House. As the Senate develops its version of the bill, your consideration of the Administration's views would be appreciated.

The Administration has previously communicated its strong objection to the overall inadequate discretionary funding level assumed in the House- and Senate-passed Budget Resolutions. The House-passed bill would reduce discretionary budget authority by over \$5.5 billion from the President's request, which the Administration believes is the level necessary to address the Nation's needs adequately.

The President strongly believes that we must invest in our country's future by supporting education and training to promote long-term economic growth, and to give average Americans the skills they need to get high-wage jobs, and, thus, raise living standards both now and in the future. Many of the programs funded in this bill would help us do just that. In addition, many others are aimed at protecting and aiding the most vulnerable individuals in our society. Reductions and eliminations proposed by the House would have a particularly harmful effect by withholding necessary services for children, youth, and the disadvantaged, and by underfunding worker protection.

As you know, the President has written the congressional leadership urging full funding of his request in this and other bills for anti-drug programs. Regrettably, this bill reduces funding for several programs that are key elements of our effort to wage an effective war on drugs.

For these reasons, discussed more fully below, the President's senior advisers would recommend that the President veto the bill if it were presented to him in its current form.

Pre-School Children

The Head Start program plays a vital role in preparing disadvantaged young children for school; its expansion should be continued, not reversed as in the House-passed bill. The President would add \$412 million and 50,000 new slots to the Head Start program in FY 1997. The House's action could reduce slots by up to 15,000 compared to FY 1996 -- assuming that quality is to be maintained -- clearly a move in the wrong direction.

Education and Training

The Administration is committed to investing in education and training programs that help average Americans build a better future for themselves and their families. More than ever before in our Nation's history, what you earn depends on what you learn. The House has systematically targeted those key programs designed to educate and train our youth and our workers for the most debilitating cuts. These cuts are especially ill-conceived considering the strict new requirements in welfare reform legislation to prepare and move welfare recipients into work.

The House's ill-advised decision to terminate funding for Goals 2000 would set back State-based efforts to improve learning for all students and to build a more competitive workforce. The House provides none of the additional funding that the Administration has requested for its education technology initiatives -- as articulated by the President in the State of the Union address -- including \$250 million for the Technology Literacy Challenge Fund, to begin to provide essential stimulus to States to help make every child computer literate by the 21st century.

By funding below the President's request: Education for the Disadvantaged, Safe and Drug Free Schools and Communities, Special Education, Pell Grants, Perkins Loans, Charter Schools, Comprehensive Regional Assistance Centers, Bilingual Education, School-to-Work, Vocational and Adult Education, and other programs, the House would eliminate aid for hundreds of thousands of children in schools across the country, and would substantially reduce aid for college. In addition, the House-passed bill would eliminate funding for the Eisenhower Professional Development Program and Star Schools, folding the funding into an untargeted block grant. This action would not ensure that sufficient funds are devoted to teacher training and educational technology programs. The House's recommended funding levels would have a severe negative impact on our Nation's future.

The House-passed bill would reduce spending for the administration of student loan programs from \$491 million requested by the President to \$420 million, a \$71 million reduction below the President's request. This would make it impossible for the Department of Education to ensure program

integrity in all student loan programs and would effectively cap the volume of direct lending. As with the FY 1996 appropriations bill, the Administration continues to oppose any cap on direct lending.

The Administration strongly opposes the House's proposal to cut summer jobs for youth by \$246 million, or 28 percent, below the President's request. This action would eliminate jobs for 134,000 disadvantaged youth. The House level is \$168 million below the amount necessary to fund the 521,000 jobs that were funded for the summer of 1996.

In addition, the Administration opposes the House's decision not to provide the \$250 million requested for the Youth Opportunities Areas initiative for at-risk youth, being pilot tested under current law this year.

The House-passed bill would reduce by \$295 million, or 13 percent, requested funding to retrain dislocated workers and low-income adults and help them find jobs through One-Stop Career Centers. This would deny training and reemployment services to about 81,000 dislocated workers and 35,000 low-income adults.

The Administration opposes the provision in the Training and Employment Services appropriation that would allow the unlimited transfer of resources between the JTPA title II-A adult training program and the JTPA title III dislocated worker program. The Administration considers the amounts appropriated for the two programs the best policy judgment of the level of resources necessary to carry out those programs. The 20-percent transfer authority included in the President's request would give States and local governments sufficient flexibility to tailor the programs to meet unforeseen local needs.

The House cuts to the State Unemployment Insurance and Employment Service (SUIESO) programs, which are almost completely financed with employer-paid Federal unemployment taxes, would have a serious impact on the States' capacity to pay mandatory unemployment insurance cash benefits on a timely basis and collect employer taxes when due. These reductions would also hamper States' efforts to provide quality services to unemployed workers, job seekers, and employers, and would severely curtail State reform efforts to implement One-Stop Career Centers.

Protecting Workers

The House-passed bill would reduce by \$36 million, or 20 percent, the President's request for the National Labor Relations Board and would reduce by \$116 million, or 12 percent, the request for Labor Department worker protection programs. As a result, there would be fewer workplace inspections, reduced aid to small businesses, and, unless inspections were reduced even further, there would be no funding for the President's initiatives to ensure pension protection and to improve workplace safety and health. Only limited funding would be available for the President's initiative to eliminate sweatshops in the garment

industry. In addition, language riders in the bill would inappropriately restrict the ability of enforcement agencies to safeguard child safety, and enforce the National Labor Relations Act. The Administration is also concerned that the House-passed bill does not fund the National Institute for Occupational Safety and Health or the former Bureau of Mines activities transferred to the Centers for Disease Control at the requested level.

The Administration opposes the 40-percent cut below the FY 1996 level for the Bureau of International Labor Affairs. The funding level provided by the House would constrain the Bureau's ability to work on child labor and workers' rights issues.

The Administration commends the House for removing the prohibition on the Occupational Safety and Health Administration's (OSHA's) ability to develop or issue any proposed or final standards or guidelines on the subject of ergonomic protection. The Senate is urged to concur with the House and to allow the Department of Labor to address the most rapidly growing workplace health problem.

Protecting Health

The House-passed bill would provide \$812 million for Ryan White AIDS Treatment Grants, \$83 million below the comparable request, adjusted for the Ryan White CARE Act amendments of 1996. Since the House completed action on the bill, the Administration has increased its request by \$65 million to \$117 million for specific funding for State AIDS Drug Assistance Program (ADAP) activities authorized in Title II. While the Administration is encouraged that the House recommended \$75 million for this ADAP set-aside, an increase of \$23 million above FY 1996, the Administration urges the Committee to fund the full request of \$117 million. The Administration is also concerned that the House funded the other activities authorized in Title II \$18 million below the President's request. The Administration urges the Committee to fund these activities at the requested level of \$233 million.

In addition, the Administration is concerned that funding provided below the request in the House bill is insufficient to keep up with increasing case loads in the 49 cities currently receiving Title I assistance and the 150 local clinics that provide Title III(b) early intervention services to those with, or at-risk of developing HIV.

The Administration is also concerned that the House-passed bill does not appropriate a specific amount for AIDS research through a single appropriation for the National Institutes of Health's (NIH's) Office of AIDS Research as requested in the President's budget. The single appropriation helps NIH target NIH AIDS research funds effectively, minimizing duplication and inefficiencies across the 21 institutes and centers that carry out HIV/AIDS research.

The House has reduced funding for the Substance Abuse and Mental Health Services Administration (SAMHSA) by \$249 million below the President's request. SAMHSA supports vital substance abuse and mental health services to many underserved Americans, such as pregnant women and high-risk youth. The House's funding level would undermine the President's anti-drug abuse strategy developed by General McCaffrey. Such a reduction is particularly troublesome given the findings of the recent National Household Survey on Drug Abuse on increased drug use among our young people. We need the Congress to join with the Administration in working to reverse this trend. The Administration therefore urges the Senate to fully-fund the President's request.

The Administration is disappointed that the House has not funded at the President's request several important programs of the Centers for Disease Control (CDC), including polio eradication and the HIV prevention program. The Administration also strongly objects to the House cut in funding for CDC's injury control activities of \$2.6 million. This cut eliminates the very funding that CDC devotes to studying the causes and patterns of violence involving guns, which CDC estimates results in over 39,000 deaths each year. In addition, the Administration is disappointed that the House has chosen to terminate the Healthy Start program.

The House has provided only one-fourth of the funds requested for Grants for the Prevention of Sexual Abuse of Runaway and Homeless Youth, despite the fact that many teenagers on the streets are exposed to exploitation and violence. And the House falls \$7.4 million short of the President's request to fund fully CDC's Violence Against Women Act programs for Rape Prevention and for Community Programs on Domestic Violence. In total, the President has requested that Congress provide the full \$109 million authorized in law for Violence Against Women Act programs -- of which the House has provided only \$96 million.

By providing no funding for the \$30 million Teen Pregnancy Prevention Initiative, the House would stall the development of critical knowledge about how to prevent teen pregnancy, and deprive vulnerable adolescents in 25 communities of essential services at a time when out-of-wedlock births are still rising.

The Administration urges the Senate to provide the full request of \$198 million for Title X Family Planning Grants. The increase proposed over the FY 1996 level would allow an additional 20,000 individuals to receive family planning services, including counseling and testing for sexually transmitted diseases.

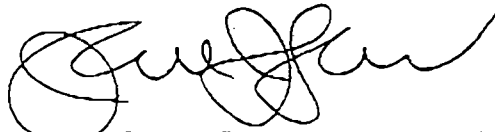
Section 514

Section 514 of the bill would prohibit the use of certain funds made available under the Act for undocumented immigrants. The provision is extremely vague, and its intent and likely impact are both highly unclear. The Administration is strongly opposed to any provision that might be read to jeopardize any

child's right to full participation in public and secondary education, including pre-school programs. The Administration prefers the language contained in the FY 1995 Labor, Health and Human Services, Education, and Related Agencies Appropriations Act, which would prohibit Federal, State, or local officials from obligating funds in violation of existing law or regulations that deny benefits.

Additional Administration concerns with legislative riders and funding issues in the House-passed bill are contained in the enclosure. We look forward to working with the Senate to address our mutual concerns.

Sincerely,

A handwritten signature in dark ink, appearing to read 'J. Lew', with a large, stylized initial 'J'.

Jacob J. Lew
Acting Director

Enclosure

Identical Letters Sent to Honorable Mark O. Hatfield,
Honorable Robert C. Byrd, Honorable Arlen Specter,
and Honorable Tom Harkin

Enclosure
(Senate Subcommittee)

ADDITIONAL CONCERNS
H.R. 3755 -- DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES,
EDUCATION, AND RELATED AGENCIES APPROPRIATIONS BILL, FY 1997
(AS PASSED BY THE HOUSE)

The Administration looks forward to working with the Congress to address the following concerns.

Department of Labor

Youth Opportunity Areas. The House-passed bill does not provide \$250 million for the President's initiative for out-of-school youth being pilot tested under current law. The initiative would provide approximately \$14 million a year to each of 15-20 high poverty urban and rural areas to increase dramatically employment of out-of-school youth.

Dislocated Workers. The House-passed bill funds dislocated worker assistance at \$1.1 billion, \$193 million below the President's request. This would reduce participation by about 81,000 relative to the President's proposal. The Administration strongly opposes language to permit unlimited transfers of funds between dislocated worker and adult training programs.

Senior Community Service Employment Program. The House reduces the share of funds for the national contractors (e.g. AARP, NCSC, Green Thumb) by about 11 percent. These contractors would be unable to provide about 3,000 job opportunities for disadvantaged senior citizens in communities throughout the Nation.

DOL Chief Financial Officer (CFO). The bill includes language that inappropriately intervenes in the internal organization of the Department of Labor. The Department is working closely with the Office of Management and Budget to finalize its CFO structure and should not be impeded by bill language.

One-Stop Career Centers. Funding for this initiative is \$40 million below the President's request. As a result, nine States would not be able to receive grants to implement the centers, which are key to adult training and services reform now, and which are included in the legislative reforms for training programs now in conference.

Employment Service. The House cuts \$82 million from the President's request, to a level that is ten percent below the request and six percent below FY 1996. Reducing the

Employment Service affects its ability to provide up-front information and job matching services to all applicants, a key element in a consolidated training and employment system.

Unemployment Insurance Administration. The House cuts this program \$150 million below the President's request. The requested level reflects the amount necessary to process the projected workload increases for unemployment benefits and tax collections. The effect would be job losses for 2,800 State unemployment office staff, closing up to 130 local offices, and delays in paying benefits.

Pension Protection. The Administration is also concerned that, at the level included by the House, safeguards for overseeing and protecting worker pensions would be inadequate. The funding in the President's request to improve data processing of annual pension reports from employers is essential to maintaining adequate pension protection for our workers.

Appropriations Language Affecting Employee Benefit Programs. The Administration urges restoration of the appropriations language included in the President's budget, which would: (1) guarantee speedy provision of employee pension benefits in the event of unexpected plan terminations; and, (2) cure accounting problems in the Black Lung Disability Trust Fund.

Child Labor Regulations. The House-passed bill includes a rider limiting the Department of Labor's ability to implement and enforce regulations for minors' incidental driving of motor vehicles. This action could result in a higher likelihood of injury and death to minors working in this area.

Enforcement of Back Pay for Illegal Immigrants. The President, the Commission on Immigration Reform, and a bipartisan majority in the Congress agree that successful control of illegal immigration requires comprehensive efforts not only to police the border, but also to address effectively the incentives for U.S. employers to hire unauthorized workers. Denying the collection of back wages for unpaid illegal workers runs directly against this policy and would contribute to incentives that employers have to hire illegal workers.

Bureau of Labor Statistics (BLS). The House cuts BLS by \$17 million below the President's request. This funding shortfall would result in further deterioration in important statistical programs and deny funds needed for the governmental initiatives to implement the new industrial classification system.

Department of Health and Human Services (HHS)

Substance Abuse and Mental Health Services Administration (SAMHSA). The House's \$88 million (seven-percent) reduction to the President's request for Substance Abuse Performance Partnership grants would reduce the funding available to States to combat drug abuse among America's youth. The House's combined \$181 million (44-percent) reduction to the President's requests for SAMHSA Knowledge Development and Application programs is also troubling and could impair progress in research and dissemination of important new ways to treat and prevent substance abuse and to help those with mental health disorders.

Mine Safety. The Administration is concerned that the House has not provided any of the \$32 million requested for the mine safety and health functions transferred from the Department of the Interior to the Centers for Disease Control (CDC).

Administration for Children and Families (ACF) and Administration on Aging (AoA) Programs. The House proposes significant reductions below the President's request for ACF Services programs. The bill does not fully fund the child welfare innovation program (\$39 million requested); eliminates funding for community-based resource centers (\$51 million requested); and funds developmental disability programs \$13 million below the \$122 million requested.

In addition, the House provides no funding for community schools within the violent crime reduction programs (\$14 million requested), cuts AoA programs (by \$18 million), and research grants for both ACF and the Administration on Aging are eliminated (\$22 million requested). The \$142 million in funding added above the requested level of \$390 million for the Community Services Block Grant (CSBG) and the \$40 million in funding added above the requested level for refugee and entrant assistance would be better used for higher priority programs such as Head Start or Violence Against Women Act programs.

Office for Civil Rights (OCR). The House-passed bill cuts OCR funding by \$2.4 million (11 percent) below the request. This reduction in FY 1997 would exacerbate the backlog of discrimination cases resulting from the FY 1996 funding cut and could lead to a curtailment of compliance activities. The Administration urges that OCR funding be restored to the level requested in the FY 1997 Budget.

Agency for Health Care Policy and Research (AHCPR). The Administration is concerned that the House includes a program level that is \$19 million less than was requested in the President's budget.

Anti-Terrorism. The House fails to provide the requested \$5 million in funding for anti-terrorism activities. This action would delay HHS' ability to carry out its national anti-terrorism program planned for FY 1997.

National Institutes of Health (NIH) -- Clinical Research Center. The House would appropriate funding for the Clinical Research Center incrementally instead of fully funding the \$310 million request. The Administration supports full-funding of fixed assets.

Small Business Innovation Research Awards. The Administration urges the Senate to refrain from adopting the provision in the House bill that would have the effect of significantly reducing the funds NIH can spend on Small Business Innovation Research (SBIR) awards. SBIR awards help support research and development conducted by small businesses, which play a pivotal role in developing biotechnological and pharmaceutical products that improve public health. The Administration supports the Porter/Kennedy agreement to delete the SBIR provision of the House bill in a conference agreement or a continuing resolution and to give NIH the discretion to determine the best way to allocate the 2.5 percent set-aside among the NIH Institutes.

Department of Education

Pell Grants. The maximum award level is increased slightly, by \$30, in the House-passed bill but is still \$200 below the President's proposal of \$2,700. Under the President's proposal, 107,000 more students would be served than under the Committee-reported bill.

Safe and Drug-Free Schools and Communities. This program is reduced by \$25 million below FY 1996, eliminating funds for national drug prevention and other violence prevention programs and reducing State grants \$74 million below the President's request. These cuts would weaken efforts to reduce youth drug abuse and would put millions of children and teachers at an increased risk of violence in their schools.

Educational Technology. The House has cut the education technology program by \$277 million below the President's request, providing no funding for the President's Technology Literary Challenge Fund initiative to help all States leverage the resources necessary to integrate technology into their school curriculum.

Charter Schools. The House has failed to provide any increase above the FY 1996 enacted level, leaving funding at \$22 million, or 55 percent, below the President's request. At the House level, 300 fewer Charter Schools could receive start-up funds than under the President's proposal.

Title I. The Education for the Disadvantaged programs are funded at \$454 million below the President's request, denying services to over 400,000 children from the poorest communities.

Special Education. The House provides \$307 million below the President's request. At this diminished level, States would have to serve about 170,000 more children with disabilities in FY 1997 without additional Federal funding.

School-to-Work. Funding for this program is frozen at the FY 1996 level, \$50 million below the President's request. Along with the comparable level in the Labor Department, this funding level would prevent the remaining 10-12 States from receiving implementation grants.

Perkins Loans. The House-passed bill terminates new funding for the Perkins Loans program, compared to the Administration's request for a \$65 million increase, thereby eliminating aid to 151,000 students.

Eisenhower Professional Development. The House-passed bill terminates funding for this program and folds it into the Innovative Education Programs Strategies block grant. The President requests \$610 million for this program, to help teachers in every State improve their skills.

Comprehensive Regional Technical Assistance Centers. The House-passed bill funds these Centers at \$22 million, \$23 million, or 51 percent, below the President's request. The Centers help schools and school districts in every State implement comprehensive reforms and improve teaching and learning.

Bilingual and Immigrant Education. The House funds Bilingual Education at \$117 million, \$39 million below the President's request, zeroing out funding for professional development and support services. The bill funds Immigrant Education \$50 million below the request of \$100 million. At this level, the Federal government would provide only \$61 for each of the 822,000 students. The President's request would double the per-pupil amount to \$122.

Departmental Management. The House would fund Departmental Management at \$379 million, \$39 million below the FY 1996 enacted level and \$67 million below the FY 1997 request. The Department of Education had already planned to reduce

employment by 137 full-time equivalents (FTE), or three percent. The additional cuts proposed by the House could result in furloughs of 20 workdays for about 2,700 Education Department employees.

Other Independent Agencies

Social Security Administration (SSA) -- Administrative Expenses. The Administration continues to support its FY 1997 Budget request and welfare reform proposal of \$250 million with a cap adjustment to implement reforms to the Supplemental Security Income program in the welfare reform legislation passed by the Congress. The welfare reform bill provides for authority to adjust the discretionary spending caps upward by \$150 million in FY 1997 and upward by \$100 million in FY 1998. The Administration urges the Senate to provide at least the \$150 million in FY 1997 for this purpose. Appropriation of those funds with a cap adjustment would eliminate the need for the additional administrative expenses funding included in the House-passed bill. Further, action taken by the House fails to allocate costs properly among the trust funds and discretionary appropriations. The Administration's scoring of the appropriations bill will reflect the appropriate allocation of these funds.

SSA -- Union Activity. The House-passed bill would bar the use of trust fund dollars to pay salaries of Social Security Administration (SSA) and HHS employees who serve as representatives of the union to work with SSA and HHS on such issues as customer service, employee security, and employee grievances. Paying for such expenses is required under the Federal Service Labor-Management Relations Statute and is consistent with SSA's and HHS's collective bargaining agreements. The Administration believes that, over the long term, improving relationships between management and employees will increase productivity, cut costs, and increase employee morale. We strongly urge the Senate to strike this limitation from the bill.

National Labor Relations Board (NLRB). The House-passed bill reduces funding for NLRB by \$26 million, or about 15 percent, below FY 1996 and \$36 million below the President's request. The House would continue a rider from the FY 1996 omnibus appropriations bill prohibiting the NLRB from promulgating a proposed rule on single-unit bargaining locations. This rider will preclude agency efforts to use its rulemaking authority in an effort to reduce time-consuming and costly litigation. The House also includes a limitation that would require NLRB to index to inflation the 1959 jurisdictional thresholds that set the level of interstate commerce (by industry) used to determine coverage under the National Labor Relations Act. While there is no empirical evidence to demonstrate that a change in

SEP-16-88 12:33 FROM: ID: PAGE 13/14

jurisdictional thresholds will increase or decrease NLRB's caseload, this change is an improper justification for the 15-percent reduction.

Corporation for National and Community Service. The House has reduced the funds provided for national service under this appropriation by \$24 million, almost 11 percent below the President's budget. This would deny over 800 AmeriCorps*VISTA participants the opportunity to serve their communities and earn an education award. In addition, almost 80,000 senior citizens would lose the opportunity to serve the frail elderly, and disadvantaged/disabled young people in their communities through the National Senior Service Corps programs, Retired and Senior Volunteer Program, Foster Grandparent Program, and Senior Companion Program.

Corporation for Public Broadcasting (CPB). The Administration is concerned with the Committee's reduction in funding for CPB. The Administration is committed to providing the necessary resources for quality public television programming and production.

Railroad Retirement Board (RRB). The House-passed bill includes language prohibiting the Inspector General from using funds for any audit, investigation, or review of the Medicare program. RRB has statutory authority to administer a separate contract for RRB Part B Medicare claims. The Administration believes that this language should be deleted. As long as RRB has authority to negotiate and administer a separate Medicare contract, the RRB Inspector General ought not to be prohibited from using funds to review, audit, or investigate activity related to that contract.

Armed Forces Retirement Home. The House-passed bill would reduce funding by more than five percent for the U.S. Soldiers' and Airmen's Home in Washington, D.C., and the Navy Home in Gulfport, Mississippi. A reduction-in-force and other severe reductions in operating costs would be required to absorb this significant funding reduction.

THE WHITE HOUSE
OFFICE OF DOMESTIC POLICY MAY - 7 1996

CAROL H. RASCO
Assistant to the President for Domestic Policy

To: ~~16 CHR~~

② Copies to JBA

Draft response for POTUS
and forward to CHR by: ~~Diana~~
~~Elrath~~

Draft response for CHR by: _____

Please reply directly to the writer
(copy to CHR) by: _____

Please advise by: _____

Let's discuss: _____

For your information: _____

Reply using form code: _____

File: _____

Send copy to (original to CHR): _____

Schedule ? : ☐ Accept ☐ Pending ☐ Regret ...

Designee to attend: _____

Remarks: _____



THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

MAY - 7 1996

May 3, 1996

Carol H. Rasco
Assistant to the President for Domestic Policy
The White House
1600 Pennsylvania Ave., NW
Washington, DC 20500

Dear Ms. Rasco:

I am writing to advise you of an important change in the management structure of the Department of Health and Human Services which, I believe, will strengthen the Department's ability to provide leadership in public health and science.

As part of our Departmentwide efforts under the Reinvention of Government initiative, I have brought the Office of the Assistant Secretary for Health (OASH) into the Office of the Secretary (OS), creating a unified corporate headquarters for the Department that brings expertise in public health and science closer to the Secretary.

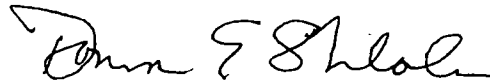
This reorganization creates a new role for the Assistant Secretary for Health (ASH), who becomes head of the Office of Public Health and Science (OPHS) a new division within the Office of the Secretary. The Public Health Service (PHS) agencies each become full HHS Operating Divisions, reporting directly to the Secretary. These Operating Divisions, the new OPHS, which includes the Office of the Surgeon General, and the Regional Health Administrators, continue to constitute the U.S. Public Health Service.

These changes will free the ASH from day-to-day management responsibility for the Public Health Service to focus on policy and program and be in a stronger position to serve the critical role of the Department's senior professional representative to the public health and science communities. The ASH will continue to be the senior public health and science advisor to the Secretary, provide senior professional leadership in the Department on population-based public health, direct the program offices within the OPHS, and at my request, provide assistance in managing the implementation of Secretarial decisions relating to cross-cutting issues involving the PHS Operating Divisions.

Page 2

The enclosed memorandum explains in more detail the new role which the ASH will play. As always, the coordination of our efforts with those outside the federal government will be crucial, and the ASH will continue to be vital in providing that liaison. We will be pleased to answer any questions you may have about the restructured Department of Health and Human Services, and we look forward to our continuing work with you toward better health for our citizens.

Sincerely,

A handwritten signature in black ink, appearing to read "Donna E. Shalala". The signature is fluid and cursive, with the first name "Donna" being more prominent.

Donna E. Shalala

Enclosure



THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

TO: All Staff

FROM: The Secretary

SUBJECT: New Role for the Assistant Secretary for Health

As you know, pursuant to our Reinvention of Government and streamlining processes, I have merged the Office of the Assistant Secretary for Health (OASH) with the Office of the Secretary, (OS), creating a unified corporate headquarters for the Department that brings expertise in public health and science closer to the Secretary.

The merger creates a new role for the Assistant Secretary for Health (ASH), who becomes head of the Office of Public Health and Science (OPHS), a new division within OS. The Public Health Service (PHS) agencies become HHS Operating Divisions, reporting directly to the Secretary. These Operating Divisions, along with the new OPHS, continue to constitute the U.S. Public Health Service, with the Secretary of Health and Human Services as its head.

The ASH will have a distinctive role within the OS, leading an office defined by a substantive area rather than by a function. The ASH will, by necessity, have a "hybrid" role, acting as senior advisor for public health and science to the Secretary and providing senior professional leadership in the Department on population-based public health and clinical preventive services. In addition, the ASH will exercise certain operational responsibilities under my direction by: directing program offices within the OPHS; providing professional leadership on cross-cutting Departmental public health and science initiatives; and, at the direction of the Secretary, providing assistance in managing the implementation of Secretarial decisions for the Public Health Service Operating Divisions.

To perform this role the ASH will:

1. Function as the Secretary's senior advisor for public health and science by:
 - serving as the senior professional representative to the public health and science communities;
 - serving as the senior professional representative on public health and science related interagency and interdepartmental task forces and as the liaison with the White House Office of Science and Technology Policy;
 - serving as the senior professional spokesperson on public health and science issues;

Page Two

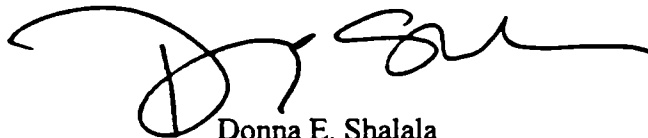
- providing advice to the Secretary in the review of budget and legislative proposals related to public health and science;
 - assisting the Secretary in developing a policy agenda for the Department to address major population-based public health, prevention and science issues; and,
 - fulfilling emergency preparedness leadership responsibilities in health.
2. Provide leadership and, as directed by the Secretary, serve as the focal point for coordination across the Department in public health and science by:
- assuring that the Department conducts broad-based public health assessments designed to anticipate future public health issues and problems and to assure that the Department devises and implements appropriate interventions and evaluations to maintain, sustain and improve the health of the Nation;
 - providing assistance in leading and managing the implementation and coordination of Secretarial decisions for PHS operating divisions, and, for that purpose, drawing on staff divisions and other units for assistance in regard to legislation, budget, communications, and policy analysis;
 - providing leadership and a focus for coordination of population-based health, clinical preventive services and science initiatives that cut across operating divisions;
 - providing leadership for and management of the OPHS that will consist of the following OS offices:
 - Office on Women's Health
 - Office of Minority Health
 - Office of Emergency Preparedness
 - Office of Population Affairs
 - Office of International and Refugee Health
 - Office of Disease Prevention and Health Promotion
 - President's Council on Physical Fitness and Sports
 - Office of Research Integrity
 - Office of HIV/AIDS Policy
 - Office of the Surgeon General
 - providing leadership and coordination with the Office of International Affairs on international health issues and representation to foreign governments and multi-lateral agencies on health issues.

Page Three

3. Through the Surgeon General, provide direction of and policy setting oversight for the Commissioned Corps as well as providing the organizational base for the Surgeon General's exercise of statutory and assigned responsibilities.
4. Assure that the PHS mission is carried out in concert with the Department's overall mission by chairing the new Public Health Council.

I have asked Dr. Lee to develop a charter for the Council that will allow it to serve as a forum for coordinating the leadership of the new Public Health Service and other components of the Department, as appropriate, to advise me on cross-cutting public health issues and activities.

This is a time of major change in the management of the Department and of the Nation's health sector. I am aware that, as with any new organizational arrangement, questions and issues arise because of the unanticipated effects of change. I know that everyone will work to resolve any problems in a collaborative manner. I am committed to strengthening public health and science programs in the Department and believe that the reinvented organization and the new responsibilities of the ASH are essential to achieving that end.

A handwritten signature in black ink, appearing to read 'Donna E. Shalala', with a large, stylized initial 'D'.

Donna E. Shalala



DEPARTMENT OF HEALTH & HUMAN SERVICES

Chief of Staff

Washington D.C. 20201

FACSIMILEDATE APR 25 1991

*JBA you
have, right?
-Eliy. I made
a copy for JBA.*

TO: (NAME, ORGANIZATION, CITY/STATE AND PHONE NUMBER):

Carol Rasco
Assistant to the President
for Domestic Policy

456-2249

FROM: (NAME, ORGANIZATION, CITY/STATE AND PHONE NUMBER):

Kevin Thurm
Chief of Staff

690-6133

RECIPIENT'S FAX NUMBER: () 456-2878NUMBER OF PAGES TO SEND (INCLUDING COVER SHEET): 7

COMMENTS:



DEPARTMENT OF HEALTH & HUMAN SERVICES

Chief of Staff

Washington, D.C. 20201

APR 25 1996

MEMORANDUM TO CAROL RASCO

As requested, attached is an overview of the Parental Rights Amendment and related initiatives at the state and federal levels. This information follows up on the April 17 *Washington Post* story on Kathleen Bush, mother of Jennifer Bush, the little girl who acted as a "poster child for the administration's attempt to reform health care." The article noted that Mrs. Bush is active in support of Florida's version of the Parental Rights Amendment, known there as the Family Bill of Rights. Please feel free to call me if you have any questions or require additional follow-up.

A handwritten signature in dark ink, appearing to read "K. Thurm".
Kevin Thurm

PARENTAL RIGHTS AMENDMENT

As was raised in an article on Kathleen Bush in the April 17, 1996 edition of the *Washington Post*, legislation allegedly protecting parents from unwarranted intervention by the government in the raising of their children is pending in Florida and a number of other states as well as the federal government. This initiative, referred to in the article as the Family Bill of Rights, is known as the Parental Rights Amendment.

Overview

The Parental Rights Amendment was one of the key provisions of the Christian Coalition's "Contract with the American Family." The main goal of this effort is to create a legal protection for parents concerning their rights to control the education and health of their children and to protect the integrity of the family. In other words, this amendment would give parents a cause of action to sue the state or federal government on the grounds that government laws interfere with a parent's right to raise his or her children.

Tone and emphasis vary from state-to-state, but most of the initiatives have two key components: (1) the right of parents to direct the upbringing and education of their children shall not be infringed; and (2) the legislature shall have powers to enforce the parental rights.

According to the supporters of the amendment, this initiative would give parents better standing to challenge topics or methods of instruction in public schools, more control over health decisions concerning their children and would give parents added standing in asserting their role as the primary shapers of family decisions. Attached is a description of the Parental Rights Amendment prepared by Of the People, a northern Virginia-based organization that advocates the amendment. Along with the Christian Coalition and Of the People, Concerned Women of America also is one of the leading groups supporting this initiative.

Opponents are concerned that such an amendment would, among other concerns, open to increased litigation such diverse issues as school sex education and the investigation and prosecution of child abuse and neglect. The proposals are opposed by all the leading education groups, many children's groups, the American Civil Liberties Union, and child abuse prevention advocates. A coalition against the proposals is being chaired by People for the American Way and the National Child Abuse Coalition.

State Initiatives

Groups supporting the amendment have encouraged members of state legislatures and the U.S. Congress to use any number of vehicles to further this proposal, including legislative proposals, bills to amend state constitutions, and state referenda.

Many state proposals include very generic and appealing language. For example, in the Virginia General Assembly, a constitutional amendment was introduced that stated simply, "The right of parents to direct the upbringing and education of their children is a fundamental right." This proposed amendment was defeated this past session.

In many other states, however, the parental rights initiatives have served as a vehicle to address all sorts of issues as well as bringing together very diverse coalitions. For example, although child abuse is not explicitly mentioned in the amendment, it has been one of the most visible issues. In some cases, it appears that these proposed bills specifically address instances of child abuse and neglect and the levels of evidence required to substantiate abuse or to remove a child from the home (Florida, Indiana and Washington state). In other instances, it appears that bill drafters do not intend for the provisions to apply in instances of child abuse (although they may unintentionally do so).

In Florida, supporters of the Family Bill of Rights include Citizens Commission on Human Rights and Victims of Child Abuse Laws (VOCAL). Citizens Commission on Human Rights is a national organization that serves as an extension of the Church of Scientology. VOCAL is a national organization with state chapters that is concerned about allegedly unjust or overly intrusive intervention by child protective services in cases of alleged child abuse and neglect.

In all, at least 14 states have pending legislation concerning parental rights. In addition to the states mentioned above, these include California, Colorado, Georgia, Illinois, Michigan, Minnesota, Missouri, Nebraska, New Hampshire, Pennsylvania, and South Carolina. The attached memo prepared by the American Civil Liberties Union foundation provides a status of parental rights legislation in those states where such legislation is pending.

Federal Legislation

On April 17, 1996, the Administrative Oversight and Courts Subcommittee of the Senate Judiciary Committee approved along party lines S 984, a parental rights bill introduced by Senator Charles Grassley (R-IA) (Senator Bob Dole is a co-sponsor). This proposal would affirm the rights of parents to direct their children's education, health care, religious instruction and discipline. Under the bill, parents could sue federal, state or local officials who they believed had interfered with their rights to "direct the upbringing" of their child without a "compelling government interest." An amendment the panel approved by voice vote exempts from the bill interference with legitimate child abuse investigations.

Attachments:

- Of the People one-pager explaining the Parental Rights Amendment
- ACLUF memo on state Parental Rights Legislation

HPF-25-1998 11-33 FROM
Jeffrey Bell
Chairman

10 915 32878 P.05
Greg D. Erken
Executive Director

Ralph Banko
President

The Parental Rights Amendment

1. The right of parents to direct the upbringing and education of their children shall not be infringed.
2. The legislature shall have power to enforce, by appropriate legislation, the provisions of this article.

The Parental Rights Amendment is expected to have impact in three major areas of public policy: education, health, and the integrity of the family.

Education: The Amendment would give parents better standing to challenge topics or methods of instruction in public schools that subvert the right of the parents of a community to have the primary role in forming their children. The public schools are and always have been a democratic institution, governed and funded by the community as a whole. Curricula and methods of study that ignore or actively oppose community values are an abuse of democracy, and a growing one. The Parental Rights Amendment, if enacted, would underline that the parents of a community have a special concern and standing in the formulation and carrying out of public education. It would give parents increased ability to challenge courses of academic and moral instruction that go against community standards. The Amendment would also enhance parents' standing to send their children to the public school of their choice.

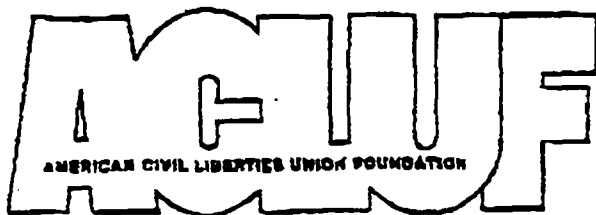
Health: The Parental Rights Amendment would more firmly establish the role of parents as the central decision-makers as to the health of their children within socially acceptable norms. It is designed to prevent such practices as the distribution of condoms to and abortions on minors without parental consent.

Family Integrity: Recent developments in the courts and elsewhere have brought it to question the legal status of the family. A state with a Parental Rights Amendment in its constitution would give parents added standing in asserting their role as the primary shapers of family decisions. It would counter the growing trend of giving children (in reality, lawyers) the right to challenge parental decisions on such previously private matters as homework, household chores, cosmetic surgery, and the like. While in no way reducing legal safeguards against child abuse or neglect, it would reassert the primacy of parents (including adoptive parents) in family life. It would counter trends like children suing parents for "divorce," a right implicit in the writing of Hillary Rodham Clinton, among others.

For further information contact Of The People, the national grassroots lobby sponsoring the Parental Rights Amendment:

Greg D. Erken, Executive Director
Of The People
2111 Wilson Boulevard, Suite 700
Arlington, VA, 22201
(703) 351-5051

OF THE PEOPLE



MEMORANDUM

To: Interested Parties

From: Estelle H. Rogers *EHR*

Date: 4/15/96

Re: State Parental Rights Legislation

At least thirteen states have introduced "Parental Rights" legislation or constitutional amendments. (In some cases, legislation was introduced and has already failed in the legislature. Some of these bills are not mentioned in the following summary.)

One state, Colorado, has a "Parental Rights" referendum expected on the ballot in the November '96 election.

CALIFORNIA: CA SCA 5 "Parental Rights in Education" - author has put this bill on hold, presumably because the chair of the Senate Health and Human Services Committee will not let the bill out of committee.

CA ACA 30 - parental rights; expected to move this week.

CA AB 2820 (school code amendment) - was scheduled for hearing 4/10/96, but author pulled it because he was working on another bill. Will probably move by the end of this week.

CA AB 2983 - "Local Control Restoration Act" - Parents shall control the instruction and education of their minor children and have an advisory role in all decisions concerning their children's participation in, and exposure to, school programs. The bill expressly provides that every parent may provide for the private, religious or home schooling of minor children. Assigned to committee but no action as of 4/11.

COLORADO: This is a referendum to enact a "parental rights amendment." The Colorado Supreme Court has rejected the ACLU's constitutional challenge, and the measure is expected on the ballot in November.

FLORIDA: SB 1072 Family Bill of Rights Act—passed Senate committee and could conceivably pass in the Senate; probably won't pass in the House, but Governor has promised to veto if it does.

GEORGIA: SR 167—dead.
HB 752—This bill was killed in committee.

ILLINOIS: House Constitutional Amendment 31—Parental Rights Amendment; no movement.

INDIANA: One sentence parental rights statute has been referred to "study committee," which will report back to legislature probably in July.

MICHIGAN: SB 271 "Parental Rights in Education" (amends school code) -pared down version added to school code 12/95.

MINNESOTA: SF 105 "Parental Rights Amendment"—died in committee when session ended 4/8/96.

MISSOURI: SJR 33—Parental Rights Amendment; still in committee as of 4/11/96; unlikely to move before the end of the session.

NEBRASKA: LR 280 CA—Parental Rights Amendment; Education committee; hearing held 2/20; will likely die when session ends at the end of April.

NEW HAMPSHIRE: Parental rights and responsibilities (I don't have a bill number)—amended to "relatively innocuous" language in the Senate; assigned to House Education Committee, but probably will go nowhere.

PENNSYLVANIA: HB 2105: not yet voted out of subcommittee; hearing took place in early February, and it is not expected to move in this session.

SOUTH CAROLINA: SJR 120 "Parental Rights Amendment"—the bill is still in Committee (Education Committee), has been since last year and doesn't look like it is going anywhere.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Chief of Staff

APR 24 1996

Washington, D.C. 20201

TO: Carol Rasco
FROM: Kevin Thurm 
SUBJECT: Responses to Your Questions

HARD
COPY of
previous fax

Sorry for the delay in getting back to you. Attached are responses to three of the questions that you raised in your memo of April 3, 1996. With regard to your fourth question which deals with Dr. Foster's role, Debbie Fine of your staff is coordinating a joint White House/HHS response.

I hope this information is helpful; please let me know if you have any further questions.

ATTACHMENT

Question 1. I have had a number of calls and inquiries within and outside the White House about the Philip Adler piece in the Washington Post on Tuesday, April 2 entitled "Preventing Polio: Don't Tamper with Success." Can you send me anything that CDC and/or AAP has put out that discusses the "other side" of this issue?

The CDC position is stated in a fact sheet, entitled "Routine Childhood Immunization for Poliomyelitis," which is summarized below for your convenience.

Oral polio vaccine (OPV) continues to be the world's most effective tool in global wild polio virus ("poliomyelitis") eradication efforts. In recent years there has been dramatic success in the global campaign to eradicate poliomyelitis. The last case of indigenously-acquired wild type polio occurred in the United States in 1979 and in the American continent in 1991. However, the virus persists in other countries elsewhere in the world. Aggressive immunization efforts and surveillance programs must continue until polio is eliminated from the world. Even in nations with zero reported cases and high immunization levels, the virus can be imported and may spread, resulting in paralytic disease.

At the same time, OPV can, on rare occasion, cause paralytic disease. There are 8-10 cases of vaccine-associated paralytic poliomyelitis (VAPP) each year in the United States. To decrease the occurrence of VAPP in the United States, the Advisory Committee on Immunization Practices (ACIP) has been considering an increasing role for inactivated polio vaccine (IPV) in the United States. Although IPV and OPV are both effective in preventing poliomyelitis in an individual, IPV is not known to cause VAPP.

The ACIP recommendations on immunization practices balance scientific evidence of benefits, costs, and risks to achieve optimal levels of protection against infectious disease. The relative balance of benefits and risks can change as diseases are controlled or eradicated. OPV is considered by most experts most effective in eliminating wild poliovirus among a population because it induces intestinal immunity which contributes to the level of immunity achieved in the community. In this case, the ACIP is working to reduce VAPP, but concern remains about the possibility of importation of wild polio virus and other implementation issues. On October 18, 1995, the ACIP working group on polio vaccination policy recommended to the full committee a sequential childhood schedule of two doses of IPV followed by two doses of OPV. This transition recommendation

of a sequential IPV-OPV schedule is expected to reduce the frequency of VAPP by 50-75 percent or more and could facilitate the final transition to an all IPV schedule in the United States. Of the ACIP voting members present and eligible to vote on this issue, the ACIP voted unanimously to recommend this sequential IPV-OPV schedule. The timing for the implementation of this change to the polio immunization schedule for children in the United States will be determined by the ACIP's polio working group.

Until the CDC accepts the ACIP recommendation through its publication of the recommendation and report in its "Morbidity and Mortality Report" (MMWR) series, CDC reaffirms the ACIP's current polio vaccination policy that relies primarily on OPV for prevention of polio in the United States. The CDC will undertake, with its immunization partners, two important steps: parents should be made aware of the polio vaccines available and the reasons why these recommendations are made; the benefits and risks of the vaccines for individuals and the community should be stated so that vaccination is carried out among persons who are fully informed.

Question 2. In the March 19 LA Times there was an article by Robert A. Rosenblatt regarding a "Clinton Administration" summit with Congress, business, etc. to "devise ways to help the baby-boom generation prepare for retirement. About 100 people will attend..." Needless to say we are getting inquiries. We assume this refers to a piece of the Administration on Aging's initiative on Redefining Retirement...about which I have seen a one page draft flyer. Can you share more with us on this "summit"?

Although the March 19th article referred to a "Clinton Administration" summit, Assistant Secretary Torres-Gil's comments were misconstrued by the reporters. In fact, the event was never intended to be the "Administration's" or a "summit." It is an invitational working meeting, and will be held on May 13, 1996. The details of this event, including the attendees, are currently being vetted through the Department, other departments, and the Domestic Policy Council at the White House. I understand that Assistant Secretary Torres-Gil met recently with Jeremy Ben-Ami to discuss this meeting, and that he plans to keep Jeremy informed of all developments.

Generally, the meeting will emphasize consumer empowerment, i.e., encouraging baby boomers as well as future generations to plan for a secure and fulfilling future through changes in behaviors, attitudes, and choices. It is not designed to address nor is it intended to address the issues of changing Medicare or privatizing Social Security.

Question 3. In the HHS weekly report of March 22-29 the President has asked Leon and myself about the New Jersey Childhood Brain Cancer Cases and expressed interest in our staying abreast of the matter. Can you send me a more in-depth briefing on this issue including current action on the matter.

The Agency for Toxic Substances and Disease Registry (ATSDR) and the New Jersey Department of Health (NJDOH) are currently addressing community concerns that have been raised with respect to a recent cancer incidence report issued by NJDOH. The report discussed a statistical increase in the incidence of childhood brain and central nervous system (CNS) cancers in Ocean County, New Jersey. This analysis further focused on Dover Township, and with additional definition on the area of Toms River. ATSDR and NJDOH are conducting the following activities in response to this issue.

Current and Planned Actions

- o On March 20, 1996, ATSDR and NJDOH staff met with Representatives Torricelli and Saxton, their staff, and staff from Representative Christopher Smith and Senator Lautenberg. ATSDR and NJDOH staff briefed this delegation on previous public health activities in the Toms River, Dover Township, Ocean County area of New Jersey. Also discussed were alternatives for a coordinated state-federal public health response with respect to increased cancer incidence in this area.
- o ATSDR and NJDOH have participated in three public meetings (March 21, 27 and April 3, 1996) in Toms River. ATSDR and NJDOH discussed the cancer incidence analyses that have been performed. In addition, ATSDR and NJDOH informed the public of our plans for responding to the findings of these analyses.
- o NJDOH, in coordination with the Ocean County Health Department, sampled school water from 23 public and parochial schools to address community concerns regarding the quality of public drinking water in the Dover Township area.
- o ATSDR and NJDOH are currently developing a detailed Public Health Response Plan (PHRP) to address the concerns of the community of Dover Township, New Jersey. The plan will be presented to the Dover Township Community Action Committee on Childhood Cancer Cluster (CACCCC) on April 17, 1996. The

PHRP will be finalized and implemented once agreement by the CACCCC is obtained. Gathering of data and information from the U.S. Environmental Protection Agency (EPA) and the New Jersey Department of Environmental Protection, needed for implementation of part of the PHRP, has already begun. ATSDR and NJDOH are also planning to tour areas of concern to the community with the CACCCC on April 18, 1996.

- o At the request of the Governor of New Jersey, ATSDR, NJDOH, and EPA Region II senior management will be briefing Governor Whitman on April 24, 1996.

Past Activities by ATSDR and NJDOH in the Toms River Area Include the Following Actions

- o In 1988, ATSDR performed a Public Health Assessment (PHA) for the Ciba Ceigy Superfund site in Dover Township. The PHA indicated that exposures may have occurred in the past, however, exposures to heavy metals were not recent enough for biomedical testing to be utilized as an appropriate follow up. Several possible current exposures were also identified.
- o Subsequently, from 1991 to 1993, ATSDR prepared a series of health consultations and reports which addressed the possible current exposures previously identified. The evaluations indicated that the current exposures were below levels that would represent a health concern, based on the data reviewed.
- o ATSDR was contacted by EPA Region 3 in February 1995 indicating that a nurse practitioner at a Philadelphia hospital had noticed more cases of cancer in children from the Toms River area of New Jersey than what she would consider normal. ATSDR, at that time, requested that NJDOH perform a cancer incidence investigation for the Toms River/Dover Township area, focusing on children.
- o NJDOH responded to ATSDR in September 1995 with a report that discussed a statistically significant incidence of brain and central nervous system cancers for children under the age of 20 in Ocean County, Dover Township, and Toms River specifically. For the Toms River sample population, 1.6 cases would be expected, and 5 were found, which is a rate three times higher than expected. Three of these five children were less than 5-years-old. The expected number of cases statistically for this age range would be 0.4, which would indicate a rate seven times higher than anticipated. The report indicated that because of the small number of cases found, it is not feasible to conduct epidemiological studies to determine potential causes for the increased incidence.

Routine Childhood Immunization for Poliomyelitis

Centers for Disease Control and Prevention, October 18, 1995

Oral polio vaccine (OPV) continues to be the world's most effective tool in global wild polio virus eradication efforts. In recent years there has been dramatic success in the global campaign to eradicate poliomyelitis. The last case of indigenously-acquired wild type polio occurred in the United States in 1979 and in the American continent in 1991. However, the virus persists in other countries elsewhere in the world. Until all countries are free of polio, no country is safe from it. Even in nations with zero reported cases and high immunization levels, the virus can be imported and may spread, resulting in paralytic disease. Aggressive immunization efforts and surveillance programs must continue until polio is eliminated from the world.

At the same time, OPV can, on rare occasion, cause paralytic disease. There are 8-10 cases of vaccine-associated paralytic poliomyelitis (VAPP) each year in the United States. To decrease the occurrence of VAPP in the United States, the Advisory Committee on Immunization Practices (ACIP) has been considering an increasing role for inactivated polio vaccine (IPV) in the United States. IPV is not known to cause VAPP.

The ACIP recommendations on immunization practices balance scientific evidence of benefits, costs, and risks to achieve optimal levels of protection against infectious disease. The relative balance of benefits and risks can change as diseases are controlled or eradicated. OPV is considered by most experts most effective in eliminating wild poliovirus among a population because it induces intestinal immunity which contributes to the level of immunity achieved in the community. In this case, the ACIP is working to reduce VAPP, but concern remains about the possibility of importation of wild polio virus and other implementation issues. IPV and OPV are both effective in preventing poliomyelitis in an individual. On October 18, the ACIP working group on polio vaccination policy recommended to the full committee a sequential childhood schedule of two doses of IPV followed by two doses of OPV. This transition recommendation of a sequential IPV-OPV schedule is expected to reduce the frequency of VAPP by 50-75 percent or more and could facilitate the final transition to an all IPV schedule in the United States. Of the ACIP voting members present and eligible to vote on this issue, the ACIP voted unanimously to recommend this sequential IPV-OPV schedule. The timing for the implementation of this change to the polio immunization schedule for children in the United States will be determined by the ACIP's polio working group.

Until the CDC accepts the ACIP recommendation through its publication of the recommendation and report in its "Morbidity and Mortality Weekly Report" (MMWR) series, CDC reaffirms the ACIP's current polio vaccination policy that relies primarily on OPV for prevention of polio in the United States. Parents should be made aware of the polio vaccines available and the reasons why these recommendations are made. The benefits and risks of the vaccines for individuals and the community should be stated so that vaccination is carried out among persons who are fully informed.

Experience has clearly demonstrated that eradication of poliomyelitis is practical and that the World Health Organization target of eradicating the disease by the year 2000 can be achieved. CDC is firmly committed to the goal of polio eradication, even as we seek to reduce vaccine associated disease.

Lan 57299.WP (4/5/96)

Briefing Document
Change in Polio Vaccination Policy in the United States

I. Reasons for re-evaluation of current policy:

- The United States has been free of wild poliovirus-associated paralytic disease since 1979, due to universal vaccination with oral poliovirus vaccine (OPV). However, 8-10 poliomyelitis cases caused by the oral poliovirus vaccine (OPV) are reported each year.
- In September 1994, an international commission convened by the Pan American Health Organization certified the Western Hemisphere as free of wild poliovirus, three years after the last confirmed polio case due to wild poliovirus.
- The WHO sponsored eradication program has achieved an 80% decrease in the number of reported poliomyelitis cases globally since 1988.
- These accomplishments prompted parents, providers, and scientists to question the risks and benefits of the current U.S. policy relying exclusively on OPV for routine immunization. An alternative vaccine (inactivated poliovirus vaccine [IPV]) is available and does not cause paralytic disease. IPV is now used for childhood immunization in Canada, France, Netherlands and Scandinavian countries.

II. Review process:

- The Advisory Committee on Immunization Practices (ACIP) initiated the current policy review process in October 1994, constituting a polio working group with the American Academies of Pediatrics (AAP) and Family Physicians (AAFP), CDC, FDA and vaccine manufacturers.
- The Institute of Medicine (IOM) was asked to assist with the policy review. During June 7-8, 1995, the IOM and CDC convened a two-day workshop in Washington, bringing together academicians, clinicians, public health practitioners, manufacturers, advocacy groups, and parents and patients with vaccine-associated paralytic disease. Five policy options were considered: (1) continuation of current OPV policy; (2) change to sequential IPV-OPV policy; (3) change to an IPV-only policy; (4) change to parental choice; and (5) discontinuation of poliovirus vaccination. The first day of the IOM meeting focused on scientific aspects while the second day focused on programmatic issues.
- ACIP reviewed the outcome of the IOM-CDC workshop during its June 28-29, 1995, meeting and endorsed development of a new polio vaccination policy with greatly increased reliance on IPV. The polio working group was asked to formulate a draft polio vaccination policy.
- The polio working group met on September 12, 1995, and agreed to recommend to the full ACIP a change in polio vaccination policy to a preferred sequential schedule of first 2 doses of IPV followed by 2 doses of OPV. Schedules using OPV only or IPV only would also be fully acceptable.

III. Policy endorsed by ACIP

- During its meeting in October 18-19, 1995, the ACIP voted unanimously (with several abstentions

due to conflict of interest) to endorse the reconstitution of the working group. The working group was asked to prepare a new draft ACIP statement on polio prevention.

- At the February 21-22, 1996, ACIP meeting, a new draft ACIP statement on polio prevention was reviewed. The committee expressed strong preference that schedules for each of the polio vaccination options should be identical, and asked that the working group review possible schedules, polio vaccine package inserts, and propose a harmonized schedule for the next meeting.

The draft statement recommends that sequential IPV-OPV is preferred; that either OPV alone or IPV alone are acceptable and preferred in some situations, and that parents should be informed about all polio vaccination options.

IV. Policy review by other advisory groups:

- The Committee on Infectious Diseases (Red Book Committee) of the American Academy of Pediatrics (AAP) met on October 14-15, 1995, and voted to change polio vaccine policy to enhanced use of IPV. A preferred schedule of the sequential use of poliovirus vaccines (2 doses of IPV followed by 2 doses of OPV or IPV) was discussed. This policy will be reviewed by other AAP committees and must be endorsed by the AAP Executive Board.

V. Benefits of the new policy:

- The key objective of the policy change is to reduce the number of vaccine-associated paralytic poliomyelitis cases by initiating vaccination with IPV while maintaining the principle advantages of OPV (i.e., mucosal immunity to limit circulation of imported virus, and secondary spread from vaccinees to contacts). The new policy is expected to:
 - Reduce the number of VAPP cases by 50-75% (from 8-10 cases to 2-4 cases). Severity of VAPP is similar to that due to wild polio virus infection; the average cost to the National Vaccine Injury Compensation Program for compensation for each case is approximately \$1.2 million.
 - Help to ensure public confidence (and compliance) with childhood vaccination. This change shows that society is willing to expend substantial resources to prevent disability and death due to a vaccine.
 - Allow greater parent participation in polio vaccination decision for their children.
 - Facilitate transition to an IPV only schedule, anticipated when global eradication has progressed further.
 - Accrue continued benefit of OPV (secondary spread and mucosal immunity) – insurance against any imported wild poliovirus

VI. Potential concerns about new policy:

- Additional cost of new schedule at current IPV price is \$10-12 million for the public sector. The cost per VAPP case averted is estimated to be \$3-4 million.

- New schedule will result in increased number of injections at first two immunization visits. In conjunction with likely replacement of DTP vaccines with safer DTaP vaccines, could result in 3-4 injections per visit at 2 and 4 months of age.
- Many physicians and parents are opposed to more than 2 injections per visit. Additional injections required by new policy could potentially lead to the need for extra visits and potential decreases in overall vaccination coverage, unless education programs for providers and parents are well planned and implemented.
 - Studies of parents in Baltimore and Atlanta indicate that when informed about both IPV and OPV and given choice, most parents prefer additional injections for IPV to risk of VAPP.
- Several groups (AAFP, COSSMHO, Black Nurses Association) have expressed opposition to increased injections and changes in immunization schedule.
- Combination vaccines will reduce number of injections and decrease resistance to change. Licensure of combination vaccines which include IPV not expected before late 1997, but combinations including DTaP, Hib and/or hep B may be licensed in 1996.
 - IOM recommendation in 1988 review of U.S. polio vaccination policy was to change to sequential schedule when combination DTP-IPV vaccine available. No combination vaccine available by 1995, while 56-70 new VAPP cases occurred during this interval.
- WHO and international community concerned U.S. policy will inhibit global eradication through diversion of funding and encouraging use of IPV in polio endemic countries.
 - ACIP has strongly endorsed global eradication strategy.
- Manufacturer of OPV (Lederle) strongly opposed to new policy.

VII. Future steps:

- The draft ACIP statement defining the new policy will be discussed during a working group meeting in April or May, 1996 and revised. Key areas to be discussed include the optimal schedule for polio vaccination and implementation issues.
- The draft statement will be made available to ACIP members and other interested parties prior to the next ACIP meeting. A public comment period will occur during the June 19-20, 1996, ACIP meeting, to allow both the ACIP members and Dr. Satcher to hear concerns about the new policy statement. Following review and formal approval of the polio prevention statement by ACIP, the statement will be submitted to the Director, CDC, for approval.
- Earliest implementation of the new policy is likely to be January 1997; the timetable will be discussed by ACIP in June 1996.
- Key implementation steps include gaining endorsement of key health care provider groups (plan meeting in late 1996); development of educational materials for parents and providers; development of new Vaccine Information Statement.

- The National Immunization Program is working with the Georgia Department of Health to initiate a pilot project to incorporate the preferred IPV-OPV schedule in public clinics in one county in Georgia. The purpose of this is to examine impediments to implementation of the new policy and evaluate parent preference for polio vaccination when informed of the three options.
- The National Immunization Program is organizing focus groups with parents to discuss key issues and concerns about the proposed new polio vaccination policy.

**Recommendations of the ACIP Working Group
on Polio Immunization Policies**

**Guidelines for a Revised ACIP Statement
Adopted by ACIP - October 19, 1995**

The ACIP working group on polio immunization policies met in Atlanta on September 12, 1995 to discuss options for the U.S. polio vaccination policy and develop recommendations and an implementation plan to be proposed to the entire ACIP at the October 18-19, 1995 meeting. The meeting was attended by ACIP members (Joel Ward, Chairman; Jeff Davis; Marie Griffin; Steve Schoenbaum; Ed Thompson; Neal Halsey); liaison and ex-officio members (Georges Peter, AAP; Steven Spann, representing AAP; Elaine Fisher and Carolyn Hardegree, FDA); vaccine companies (Peter Paradiso and Jill Hackell, Wyeth-Lederle; Stanley Plotkin and David Williams, Pasteur-Merieux-Connaught); consultants (John Modlin, Dartmouth; Reg Finger, Kentucky Dept of Health), and CDC staff (Snider, Malone, Orenstein, Hadler, Wharton, Sutter, Strebel, Bisgard, Chen, Lloyd).

After the presentation of data and extensive discussion, the following recommendations were agreed upon by the majority of the ACIP members of the Polio Working Group (Drs. Ward, Davis, Schoenbaum, Griffin, Thompson, and Halsey).

1. A major revision and update of the ACIP recommendations on polio vaccines is needed as the last drafts were prepared in 1982 (OPV) and in 1987 (eIPV).
2. The preamble to this revised statement should include the following information:
 - o In recent years there has been dramatic success in the global campaign to eradicate poliomyelitis. The last cases of indigenously acquired wild type polio occurred in the United States in 1979 and in the American continents in 1991. Disease due to wild type poliovirus has also been eradicated in most developed and many developing countries. As a consequence, the risk of imported disease due to wild-type poliovirus has been greatly diminished and there is hope that the worldwide polio eradication may be fully achieved by the year 2000.
 - o In the U.S. and worldwide this achievement was accomplished largely by the widespread use of OPV vaccine.
 - o There continues to occur 8 to 10 cases per year of vaccine associated poliomyelitis (VAPP) in the U.S. Although this risk is very small (about one case per 2.4 million doses administered), there has been a change in the overall risk to benefit assessment. There are both societal and individual perspectives to this assessment.
 - o Enhanced potency IPV vaccines have been developed and are being used for routine polio immunization in several European countries and in Canada, and this contributed to polio eradication in these countries.
 - o The elimination of indigenous polio in the U.S. can only be maintained by reducing or eliminating the risk of transmission. Therefore, the ACIP reaffirms its support of the global polio eradication initiative (PEI) and urges that continuing and adequate support be made available to the PEI to achieve the year 2000 global eradication goal.

3. The ACIP will now recommend an expanded use of IPV vaccine. An IPV only regimen will be preferred when the risk of reintroduction of wild poliovirus is remote and there are no overriding concerns about implementation of an IPV schedule. With the validated eradication of polio worldwide, there ultimately should be no need for routine polio immunizations.
4. The working group identified a number of potential impediments to implementation of an all IPV immunization policy, and agreed that most would need to be overcome before an all IPV immunization policy could be recommended. These factors include the following:
 - o The assurance of an adequate supply of IPV
 - o Reduction in the cost differential between IPV and OPV
 - o The need to maintain a long term supply of OPV adequate for potential outbreak control
 - o The current status that no combined IPV vaccines are licensed or near licensure
 - o Extra injections and immunization visits will be required and could lead to increased costs and may decrease compliance with immunizations for polio and other childhood diseases.
 - o A reduction in secondary immunization from OPV
 - o Reduced mucosal immunity from IPV compared with OPV
 - o The need to reinforce surveillance for detection of potential adverse effects of IPV.
 - o The need for education of parents, providers and the general public about the need and rationale for a change in polio immunization policy.
 - o Public health implementation programs need to be developed.
 - o The need to aggressively assure continued progress in worldwide polio eradication so as to decrease further the risk of poliovirus importation.
5. Until such time that an all IPV immunization schedule can be universally recommended, the preferred US recommendation will be for a sequence of IPV/OPV vaccinations. The specific sequential schedule has yet to be firmly established, but would likely include two doses of IPV at 2 and 4 months of age followed by 2 doses of OPV at 6 and 12-18 months of age or at 12-18 months and 4-6 years of age. This is seen as a transition ultimately to an all IPV regimen. A specific schedule will be developed by the working group.

The sequential IPV-OPV schedule was preferred because two doses of IPV followed by two doses of OPV should reduce the frequency of VAPP by 50-75% or more and will facilitate the ultimate transition to an all IPV schedule. IPV should now be stocked by all immunization providers thus enhancing access and expanded use. Further, the benefits of mucosal immunity and vaccine virus spread from sequential IPV-OPV should be equivalent to that following three doses of OPV. Lastly, this schedule will not require additional injections in the second year of life, thus reducing the need for additional visits during the most difficult time to vaccinate young children.
6. Although not to be preferred, recommendations for an all IPV or an all OPV vaccine schedule should

be fully considered acceptable and be endorsed by the ACIP.

7. The advantages and disadvantages of each of the three potential schedules are reviewed and recommendations provided for the selective use of one regimen in relation to the others (appendix 1)
8. As part of the proposed change in policy, immunization providers will need to stock IPV.
9. Considerable educational efforts must be initiated soon regarding the reasons for the revision of polio vaccination recommendations.
10. The availability of combined vaccines would greatly facilitate the implementation of a sequential IPV/OPV or an IPV vaccine policy.
11. A precise timetable for implementation will be developed by the working group. Nonetheless, work should commence to revise the current statement and recommendations for review at the February 1996 meeting.