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MAR 14 1994

March 11, 1994

Kristine Gebbie RN, MSN
Executive Office of the President
750 17th Street, NW Suite 1060
Washington, DC 20503

RE: MS #OC4208, U.S. HOSPITAL CARE FOR... by Andrulis et al

Dear Dr Gebbie:

We would be grateful if you would review the enclosed manuscript and comment on its suitability for publication.

Please use the enclosed forms for your opinion. Provide your comments and suggestions to the editorial office on page 1 and those to the author on pages 2 and 3. You should not comment on the acceptability of the manuscript on pages 2 and 3. If your comments are prepared on a word processor, you may print them out on your own paper. Please provide four copies, if possible.

We consider this manuscript and your review of it to be confidential, not to be shared with others. If you need to consult colleagues to help with the review, please inform them that the information is confidential. Reviewer identities are not revealed to authors.

We recognize that most conflicts of interest are not disqualifying, but request that you indicate any conflict in the space provided on the form. If you perceive that you have a disqualifying conflict of interest, either financial or otherwise, please return the manuscript unreviewed (if possible, with the names of alternative reviewers). This will not affect your reviewer status in any way.

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Please return your review by April 1, 1994. If this is not possible, please return the enclosed manuscript packet without delay.

Many thanks for your help.

Sincerely yours,

Helene M. Cole/gls

Helene M. Cole, MD
Contributing Editor, JAMA
(312) 464-2442
HMC:gls
Enclosure

The Journal of the American Medical Association

Please make one copy for your files and return the original forms to the editorial office with the manuscript and original artwork. Page 1 will not be sent to authors, but it may be summarized or excerpted for them. If your comments are prepared on a word processor, you may print pages 2 and 3 on your own paper. Please provide four copies, if possible.

COMMENTS FOR EDITORIAL OFFICE

Manuscript Number: OC4208 Manuscript Classification: Original Contribution

Manuscript Title: U.S. Hospital Care for HIV-Infected Persons and the Role of Public....

Author(s): Dennis P. Andrulis, PHD, MPH et al

JAMA Editor: Helene M. Cole, MD

Date Sent to Reviewer: March 11, 1994 **PLEASE RETURN BY** April 1, 1994

RECOMMENDATION
- ☐ Accept as is
- ☐ Accept if suitably revised
- ☐ Revise and reconsider
- ☐ Reject

QUALITY
- ☐ Superior
- ☒ Good
- ☐ Fair
- ☐ Poor

PUBLICATION TIMING
- ☐ Routine
- ☐ ASAP (Somewhere between these!)
- ☐ Fast track

PRIORITY (Low) 1 2 (3) 4 5 (High)

REFER TO ANOTHER AMA JOURNAL?
- ☐ *Am J Dis Child*
- ☐ *Arch Dermatol*
- ☐ *Arch Fam Med*
- ☐ *Arch Gen Psychiatry*
- ☐ *Arch Intern Med*
- ☐ *Arch Neurol*
- ☐ *Arch Ophthalmol*
- ☐ *Arch Otolaryngol Head & Neck Surg*
- ☐ *Arch Pathol Lab Med*
- ☐ *Arch Surg*

VALUE	YES	NO	UNCERTAIN	N/A
Material original?	☒	☐	☐	☐
Data valid?	☒	☐	☐	☐
Conclusions reasonable?	☒	☐	☐	☐
Information important?	☒	☐	☐	☐
Writing clear?	☒	☐	☐	☐
General medical interest?	☐	☐	☒	☐
Tables/figures appropriate? If not, explain.	☒	☐	☐	☐
Editorial needed?	☐	☐	☒	☐
If yes, I volunteer to write such, or I suggest Bruce Vladek, HCFA Administrator	☒	☐		

GENERAL COMMENTS FOR EDITOR

generally good paper, and useful addition to the literature for those following the HIV epidemic & its impact on U.S. care system.

Needs some clarification/editing - see specific queries/comments next page. Where data do not allow clarification, the limitations should be more clearly spelled out.

☐ I disclose below my conflict(s) of interest in reviewing this manuscript.

Kristine Gebbie, RN, MSN — *Reviewer Name*

Reviewer Signature

3/29/94 — *Date*

PLEASE PROVIDE YOUR GENERAL AND SPECIFIC COMMENTS TO AUTHOR ON PAGES 2 AND 3

GENERAL AND SPECIFIC COMMENTS OF REVIEWER TO AUTHOR

JAMA

Manuscript Number OC4208

Author(s) Dennis P. Andrulis, PHD, MPH et al

Manuscript Title U.S. Hospital Care for HIV-Infected Persons and the Role of Public...

Specific Comments

Refer to Page	para	
overall		lack of data on characteristics of pts by region or over time limits interpretability ... regionally & over time shifts in demographics of HIV+ population (% substance abusing, % women, % infants/children) have been substantial & if available could facilitate real use of this work in program planning
2	1	Be clear that "1931 hospitals surveyed" = unduplicated #
7	2	Is there any way to clarify whether the most affected areas within a region (NYC in Northeast; Miami in South; San Francisco/LA in West) were adequately included?
8	1	Reporting on # of admits or days not very meaningful without info on size of institutions ... use of proportion more appropriate. Given generally reported variation in LOS by region, it would be nice to know if the variation in LOS for HIV was about the same as generally the case (it may reflect systemic issues or practice patterns) or differed (may reflect demographics of epidemic or differences in payment policies)
8/9	3/1	Should acknowledge regional data blurs variations in Medicaid policies (extent of coverage & reimbursement rate) which maybe significant.
10/11	3/1-2	Discussion might point out that findings are consistent with other reports on earlier diagnosis, shorter stays, interest in use of hospice/home care at end of life
10/11	all	Lack of regional data in longitudinal data limits

GENERAL AND SPECIFIC COMMENTS OF REVIEWER TO AUTHOR

JAMA

Manuscript Number OC4208

Specific Comments

Refer to Page	Refer to para	
		analysis of LOS, admits/year, which may be varying in different ways given different demographics of epidemic regionally.
14	2	Use of charges rather than costs as basis for discussion of "losses" can be misleading, and some acknowledgment of this would be appropriate.

PROJECT inform

FAX COVER PAGE

To: Kristine Gebbie		From : Martin Delaney
Fax Number : 1-202-632-1096		Company :
Date : 3/11/94	Time : 16:27:54	For Information Call: 415-332-0184
Subject :		Fax Number : 415-331-2114

Kristine,

Please note the enclosed correspondence and the underlying issue. It is very frustrating to have this problem come up now, since the issue had been resolved in past years. We had a clear and workable mechanism for handling such situations, but it appears that FDA is somehow going backwards.

Martin Delaney

Rush to Jackson / Beswick for follow up @ FDA
Alice may know something of this as well

Created using WinFax PRO 3.0 Delrina Technology Inc.

PROJECT inform

Dr. David Kessler
Commissioner, US Food and Drug Administration

March 11, 1994

Dear David,

I am writing to express my concern about actions being taken by the agency regarding shipments of albendazole to specific physicians, arranged through the PWA Health Group in New York. I assume you have heard from others about the issue, so I won't waste your time repeating the details. The bottom line is that this is a reasonable, putative therapy for an otherwise untreatable complication of AIDS, and we are aware of no specific or unusual concerns about toxicity in the Mexican-made product. In past such situations, the agency has shown flexibility in permitting individuals to import small supplies of similar medicines, and has also recognized that many people need assistance in this process, and therefore has allowed importation of modest bulk packages for groups of patients. When we worked out the mechanisms which permitted this a number of years ago, both sides agreed that such multiple shipment would be more acceptable if prescriptions were included naming the physicians and individuals for whom the medication was intended.

In this instance, a small bulk shipment has been seized and the Regulatory Affairs people in Cincinnati have been relentless in their hold. As grave as we consider this, the agency has added a much more offensive action this time, in that it has harassed and threatened the physicians whose names were included (as requested by FDA) in the shipments. Is this simply a consequence of another turnover in agency personnel? Have new people been given responsibility for this matter, people who may have no knowledge of the previous agreements? Or does it signal a radical and ominous change in agency policy, one which moves away from the spirit of cooperation we had achieved and toward a return to confrontation? If so, then confrontation is indeed what the agency will get.

This matter has already been addressed through AIDS Office, but Dr. Wycoff has announced that it is out of his hands and must be addressed through Regulatory Affairs. Since Regulatory Affairs is where we addressed such problems before, I suppose this is acceptable. However, our past dealings with the Regulatory Affairs group proceeded with a clear sense of oversight by the Commissioner's Office. Thus, I hereby request that you involve your office directly in this matter. This dispute could not come at a more sensitive time, as people with AIDS nationwide are perhaps as fed and distrustful of the government's handling of AIDS as any time in the past 10 years. I would regret to see the progress we all achieved in the past now be threatened by an unnecessary and pointless bureaucratic reaction.

Please find out what is going on here, and insist that this problem be solved. If the current mechanisms for importation are no longer acceptable, then let's begin negotiating an alternative. I think the record is clear that people with AIDS, especially such responsible groups as the PWA Health Group, have not abused this policy in any way.

Sincerely

Mark Delaney

Founding Director, Project Inform

CC: Kristine Gebbie; PWA Health Group; John S. James

1965 MARKET STREET, SUITE 220
SAN FRANCISCO, CALIFORNIA 94103

ADMINISTRATIVE OFFICES
415-558-8669

FAX:
415-558-0684

LOCAL HOTLINE
415-558-9051

NATIONAL HOTLINE
800-822-7422

[redacted]
150 W. 26 STREET, SUITE 201
NEW YORK, N.Y. 10001

PWA HEALTH GROUP

[redacted]
(212) 255-0520
Fax: (212) 255-2060

March 7, 1994

Dear all,

The PWA Health Group is getting harassed by the FDA and would like your help.

CHRONOLOGY OF EVENTS
Since our inception in 1987, the PWA HEALTH Group has been importing packages into this country with no problems.

Several weeks ago, we initiated a shipment from Mexico of Albendazole. This product is a treatment for Microsporidiosis, an intestinal bacterial infection that People With AIDS are susceptible to. This bacteria causes PWAs to have incessant diarrhea (see attached sheet). *There are currently no other treatments for microsporidiosis.* **Albendazole is approved for use and marketed in Mexico under the name of Zentel.**

As specified in a 1988 FDA Talk Paper, every American has the right to import medications that have been approved in other countries for personal use (defined as how much you would take for 3 months). **This package falls into that personal use importation policy.**

This package was stopped in the Cincinnati FDA office on February 22, by two men who work in the Regulatory Affairs office. These men, Bill Sedgewick and Ron Smith (513-684-3501) claim these packages don't fall under the personal importation policy. The package was accompanied by eight prescriptions from various doctors. Several of the prescriptions were written in the past several months and some of the people are now deceased. Mr.'s Smith and Sedgewick are now holding the same package for the second week with no end in sight. Additionally two later packages are now being held with no end in sight.

On March 1, we had contacted the FDA Office Of AIDS and Special Affairs to complain about the unfair treatment our packages were receiving in Cincinnati. Randy Wykoff, Director and Donald Pohl, Assistant Director both lauded us for contacting them and working with them on this problem. In fact later that day, both men assured us that they had solved the problem and our package would be released imminently.

By last Friday, our package was still not released, and the harassment of doctors began. On Friday March 4, the guys in Cincinnati began harassing some of the doctors who had written Albendazole prescriptions, to warn the doctors of about

[redacted]

participating in a "drug smuggling ring" with "potential for a criminal charges" if they don't comply with the investigation. After hearing from one of these harassed doctors, the staff of the PWA Health Group called the FDA Office of AIDS and Special Issues to complain of this outrageous harassment. After an internal FDA meeting on Friday March 4, Randy and Donald let the Health Group know that their office would no longer be involved in this issue and that we must work through the Office of Regulatory Affairs (Associate Director Ronald Chesemore: 301-443-1594).

In the meantime, PEOPLE WITH AIDS ARE DYING BECAUSE THEY DON'T HAVE ACCESS TO ALBENDAZOLE. SmithKline Beecham, has a compassionate use policy that is getting drug to very few people. To get on the program, doctors must call SmithKline and have the medical tests of their patients, including colonoscopy, near them to go over with the person at SmithKline.

We have operated openly for six and a half years, working closely with the FDA and PWAs to expand treatment options for PWAs. We have been openly importing albendazole, tinidazole, and isoprinosine from Mexico for years now.

What is the FDA doing?
Such high-handed un-useful enforcement procedures are exactly what the FDA should not be doing. **Call or fax Commissioner Kessler.** Since he obviously doesn't understand what microsporidiosis is, we've provided a four page info sheet to fax him. Tell him that your life matters, that AIDS matters, that PWAs should not be harassed over well-known drugs that have been in use for years and represent the only known treatment option for microsporidiosis.

Important phone and fax numbers

Dr. David R. Kessler, Commissioner FDA
phone 301-443-2410
fax 301-443-3100

Ronald Chesemore
Assoc. Commissioner Regulatory Affairs
phone 301-443-1594
fax 301-443-6591

Randy Wykoff
Assoc. Director AIDS and Special Affairs Office
phone 301-443-0104
fax 301-443-4555

Bill Sedgewick
Ron Smith
FDA Regulatory Officers
phone 513-684-3501
fax 513-684-6594

faxed 4/8

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MAR 18 199

JOURNAL OF PUBLIC HEALTH POLICY

208 Meadowood Drive, South Burlington, Vermont 05403 Tel. (802) 658-0136 Fax (802) 862-4011

March 14, 1994

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator
750 17th Street NW
Suite 1060
Washington, DC 20503

Dear Kristine:

I should greatly appreciate your reviewing the enclosed paper which has been submitted to the Journal. Please use the attached form for your comments.

If you cannot review this paper within the next three weeks, please return it *at once.* This request is made in order that contributors may not have to wait inordinately long periods of time before hearing from us.

Thank you very much for your help.

Sincerely,

Milton Terris, M.D., M.P.H.
Editor

MT/R
Enc.

"National Health Care Reform Minus Public Health: A Formula for Failure"
Freeman/Robbins

JOURNAL OF PUBLIC HEALTH POLICY

208 Meadowood Drive, South Burlington, Vermont 05403 Tel. (802) 658-0136 Fax (802) 862-4011

REVIEWER'S COMMENTS

(Although this journal follows the usual practice of maintaining strict anonymity of reviewers, it is sometimes both useful and encouraging to authors to know the stature of those who comment on their work, particularly when the comments are favorable and specific suggestions are made to improve the paper. If you are willing to be identified, please indicate this below.)

The paper develops, more clearly than many other similar discussions, the process by which the public health issues get overlooked in reform.

The authors are apparently unaware that the President's proposal includes significant funding to rebuild public health infrastructure (HR 3600/S 1757 p. 564), ~~though~~ these issues are not well discussed in the Health Security publication used as a source by the authors, and their point about integration of the community-based public health services with personal care services & financing ~~is~~ is very well taken. The paper would be stronger if reference to the ~~proposed statutes~~ were included along with the criticisms.

I would fail my former Washington State colleagues if I did not point out that one state is well along the road to developing a reform which includes public health. It would be interesting to publish this paper with a commentary from someone working on the very issue at the State level.

There is no recognition of the work currently underway among a variety of p.h. groups to assure that some version of a public health improvement process is kept in whatever plan passes. While there are no published references this material is generally available to those in ph leadership activities.

Name KM Hebbie

☒ You may use my name.

National Health Care Reform Minus Public Health: A Formula for Failure

by

Phyllis Freeman, J.D.[1] & Anthony Robbins, M.D.[2]

Introduction

Because renewed energy for health care reform springs from perceptions of risk that center more on economic than on physical vulnerabilities, so too do the remedies. Detailed attention from dozens of consultants to cost containment and to financing universal access to medical services has obscured what should be a decisive distinction between proposals. Do they attend to improving health and reducing disease or only to paying for diagnosis and treatment for those already ill?

Proposals now under serious consideration by the Congress would guarantee Americans payment for doctor visits and hospital services. A great start! But none promises to integrate the medical care system with the public health structure and assure participation of medical care providers in those functions necessary to detect and respond early to health threats. If we accept the pervasive misperception that universal access to medical services will address all important health needs, we will miss a magnificent chance to prevent disease--and to hold off unnecessary medical care expenditures. Moreover, if we do not get this right now, the door of political opportunity may not open for a second chance for many years.

Impending health care reform could take advantage of the extensive medical services system--at little additional cost--to accomplish many previously unattainable health goals for the nation. But nothing about the planning process or debate so far makes that outcome seem likely. Repeated references during the debate on health care reform to "access to prevention services" belie a failure to understand the difference between insuring personal health services and assuring public health gains. The distinction is a strategic one. Public health is grounded in the Constitutional authority to protect the health and safety of the entire population. In contrast, medical care is oriented to the needs of individuals. Medical services can be preventive, curative or palliative. Good medical care can have a favorable effect on public health even if the services were not offered as features of a population based strategy. But our nation will never achieve optimal health from our enormous investments in the medical care system without explicitly integrating public health guidance and accountability into the reform of medical care management and finance. Medical care is an element of public health, but the sheer enormity of the medical care system means that it is seen as separate.

---

[1] Phyllis Freeman is a Senior Fellow at the McCormack Institute of Public Affairs and Associate Professor in the Law Center at the University of Massachusetts.

[2] Anthony Robbins is a Professor of Public Health at Boston University School of Medicine, Boston, Massachusetts.

Because attention to public health authority has waned, few professionals remaining in the states or in the Public Health Service can imagine how to marry the tremendous momentum for reform of the medical care industry to a public health strategy designed to achieve gains in public health. Yet each state needs to make use of the expanding federal role in health care reform and of the state's Constitutional police powers to regulate aspects of medical practice to achieve health benefits for all. The federal health care reform law should make it possible.

Public health reaches far beyond the current popular notion of prevention, which focuses on individual lifestyle rather than on social, economic, and environmental hazards that few individuals can avoid without strong protective legislation and enforcement by the state. Chemical hazards in workplaces, polluted air and water in residential communities, contaminated food in supermarkets and restaurants and spread of infectious diseases by people, animals and food all pose health risks that can be reduced more efficiently by public health interventions than by medical care. And even when costly medical services can diminish or cure the harm to individuals caused by environmental exposures, other deadly threats remain where medical care is impotent regardless of how much the individual or society would be willing to spend.

Medical practitioners and institutions can be effective players in public health by systematically performing certain functions: 1) detecting problems in patients which may provide early warning of health threats to others in the community and reporting these to public health authorities for investigation; 2) relying on public health alerts to target preventive, diagnostic and therapeutic services, and 3) delivering certain services with high public health value to every patient, whether or not the patient is sufficiently aware of the risks and benefits to seek care.

In the following section we analyze why the architects of reform have concentrated on insurance and the organization of medical care while neglecting to integrate public health functions that can conserve resources and enhance effectiveness. Next we identify crucial functions missing from all reform plans, the absence of which will inhibit gains in health and allow unnecessary escalation of costs. We summarize essential uses of public authority, federal and state, to direct and discipline medical care institutions to fulfill their public health potential in concert with public health authorities. Finally, we use immunization to illustrate how medical care can be employed effectively in pursuit of public health.

Universal Sickness Insurance Posing as Comprehensive Health Care Reform

Why has the debate about health care reform neglected public health? Health insurance is a necessity for every American. It buys medical services and avoids personal financial disaster. The ultimate purpose of health care reform as currently debated in the United States is to pay for insurance against the costs of illness. This narrow focus on sickness insurance misses opportunities to improve health, yet it is perfectly tuned to the concerns of the public.

In the 1992 presidential election, concern about medical care and insurance placed second only to that for the overall state of the economy. Insurance is not a luxury but a necessity. During the campaign, the private foreboding of hard working voters was televised so the entire electorate was exposed to their pain and shared in a growing sense of national insecurity.

The testimonials brought the national statistics to life. An uninsured worker who had lost his health, his job and his life savings to an illness was one of thirty-five million Americans who had been without insurance during the average month of 1990 and risked the same fate. By 1990 there were eleven million more uninsured citizens sharing this jeopardy than there had been ten years earlier. Another trend was the increasing share of vulnerability borne by families where someone was employed. Of all full time workers, 13 percent were uninsured in 1990--and a full two-thirds of the uninsured were workers and their families. Overall, one-quarter of the entire US. population--or 63.3 million--had been uninsured for at least one month in a 28-month period during 1986, '87, and '88.[3]

The astonishing rate of growth of medical care expenditures--more rapid than any other part of the consumer price index--is a focal point for apprehension. Patients receive an ever increasing quantity of services. Services are increasingly complex, costing more per unit to produce. The Health Care Financing Administration predicts that expenditures will continue to grow by 9.2% per year. Each year there are new legislative proposals to contain medical care costs and the Congressional Budget Office estimates anticipated "savings" which never materialize. And each year Americans dedicate more weeks of work exclusively to paying their share of medical costs--just over three weeks of average wages in 1980 and almost five in 1989.[4]

Those who foot the bill for medical care--government, non-government insurers, employers, and citizens--are all engaged in efforts to reduce their financial responsibility and to shift the burden to others. Government tinkers with eligibility rules and benefit limitations for Medicaid to limit spending growth. Under these pressures Oregon initiated rationing for Medicaid patients, limiting recipients to those medical services the state deemed most cost effective. No similar limits have been placed on insurance plans for the more affluent. Insurance companies raise premiums, screen out applicants and limit coverage. This reduces workers' ability to change jobs where a "preexisting condition" may be grounds for exclusion from the new employers' group plan--if there is one. Employers in the squeeze are likely to increase each employee's contribution or to cut health benefits from the package. According to a 1991 *New York Times* poll, one-third of those with family incomes below $15,000 and more than one-

[3] D. U. Himmelstein and S. Woolhandler, The National Health Program Chartbook, (Cambridge: The Center for National Health Program Studies, 1992), 3-7.

[4] Ibid., 1.

half of those with incomes above $30,000 had been subjected to this practice within the previous year.[5]

Entirely appropriate national anxiety about health insurance has shaped the proposed solutions. There will be the inevitable protracted battles over details but three characteristics dominate most versions of national health care reform:

First, we will begin by paying for all existing resources in the health sector: doctors, nurses, hospitals, nursing homes, and most of their administrative staffs. Even health insurance companies or similar entities--and the administrative costs associated with billing and payment--are likely to survive. To assure payment for less than we buy today would result in economic dislocation and slowing of general economic growth. That would be politically unacceptable. The health sector represents almost 15% of the gross national product and accounts for a comparable fraction of employment.

Second, restraining future expenditures will be a principal goal. The President's advisors envision a combination of rationing and an aggregation of buying power in the hands of "informed" representatives of consumers, employers, and government--not unlike insurance companies or HMOs today.

Third, enrollees will be guaranteed standard or minimum insurance coverage for medical services expenditures. Not everything will be included, so life saving medical services will undoubtedly come first.

No proposal before the Congress approaches reform from a public health perspective. Yet, if we fail to build into the reformed structure of medical services a way to guarantee those measures that can improve health and dampen the need for medical services, it will be a formula for failure. The costs of unnecessary disease will burden the medical care system, and the health of our people will improve far more slowly.

Beyond Insurance: Incorporating Better Health into Reform

To achieve the full health potential of the $900 billion already spent in the health care sector we need to recognize additional ways to improve health, protect life and make effective use of our medical care resources.

The reformers have started down one promising path when they anticipate incorporating in the benefit package a class of personal health services known to have positive impact on the health status of the population. Within this class there are two distinct categories: 1) medical services which are protective for the community as well as for the individual, such as immunizations or treatment for tuberculosis, and 2) those which tend to improve the health when provided systematically to all at risk. Screening and treatment for high blood pressure or glaucoma are examples. Reformers talk about reaching optimal coverage for

---

[5] Ibid., 18.

these services through quality control mechanisms, such as "report cards."[6] Today our record on pap smears, glaucoma testing and high blood pressure detection is rarely complete, even in managed care settings.[7] Under health care reform, if the quality control approach works, we are likely to see improved preventive services. But will we see successful control of tuberculosis, toxic exposures, and other public health threats?

In 1983, the Centers for Disease Control was planning a campaign to eliminate tuberculosis. Effective antibiotics were available to render each TB patient non-infectious. All that was needed was a systematic way to screen, treat and monitor several thousand people. Yet without organized and accountable medical services, state tuberculosis programs in health departments had no way to insist that providers of personal health services help. Ten years later the situation is far more grave. Resistant TB organisms are increasingly common, rendering antibiotics ineffective, and the national objective has slipped from elimination to control. If medical practitioners had been engaged in the tuberculosis elimination plan that was proposed in 1983, today our nation might not be searching for over a half billion dollars of new money to control the spreading epidemic of multi-drug resistant tuberculosis which so threatens health care workers and others.[8]

Success in public health terms depends on how public health makes use of the medical care system. Public health authorities should be able to deputize health plans and practitioners, engaging them in managing treatment to protect individuals and the community. Success in the face of challenges to health like tuberculosis remains unlikely under reform. Medical care lacks a tradition of reaching out to patients in need of care who may not seek it. Thus we remain unlikely to provide these people with the therapy to treat themselves and protect the community around them. Society as a whole will suffer little if physicians wait for patients to seek medical care for most problems, but we all pay for missed public health opportunities. Below we use immunization to illustrate how doctors can become more effective protagonists of public health in a reformed scheme.

Fundamental public health information systems and intervention strategies--the health care analogs of smoke alarms and fire fighting--should be integrated into the health reform bundle. Epidemiology, research and public health information systems are not personal health services. They do not slip easily into an existing niche in medical insurance schemes--the benefit package. But public health systems should be so embedded in reform that they cannot be

6 In the Clinton plan a National Quality Management Program would develop a core set of performance measures that would apply to all institutions, plans and practitioners. The National Health Board would publish annual performance reports. These have been called "report cards." See The President's Health Security Plan by The White House Domestic Policy Council (New York: Times Books, Random House, 1993), 113-4.

7 Even completion in testing the entire population at risk is not sufficient protection. If quality of laboratory procedures is not maintained, results of pap smears or other tests become unreliable and of little benefit to prevention and early intervention.

8 Centers for Disease Control, Addressing Emerging Infectious Disease Threats: A Strategy for the United States. (Atlanta: Centers for Disease Control: April 1994.) In press.

uncoupled from medical care now or in the future. If cohesion is not assured at the start we will consume our limited resources caring for the equivalent of increasing numbers of smoke and burn victims as preventable problems spread--unnecessarily.[9]

The medical care system can do more than respond with targeted treatment. Medical practitioners can and should strengthen public health capacity by detecting in individuals medical problems which might have been preventable if discovered earlier and reporting such occurrences to the authorities responsible for controlling further exposures. For example, when a physician discovers that a patient with a neuropathy is suffering from solvent poisoning from his job in a plastics plant, it should be standard practice to report the event and the danger to public health authorities who may be able to protect fellow workers. Similarly for lead poisoning, rat bites, and exposures to environmental toxins, the medical practitioner must be linked to public health authorities who can intervene at the source as well as directing populations to early treatment--secondary prevention.

Reporting of disease is critical for public health, yet there is no reliable system in place to ensure doctors will report suspicious cases or that public health authorities will investigate them in the field and in the laboratory and act to prevent additional illnesses. Everywhere diseases are under-reported because physicians do not see themselves as part of a public health system to prevent disease, except for the patients in their own practice. Too often physicians do not make the effort to comply with state reporting requirements because in caring for sick patients, they may not see the cumulative consequences of reporting failures or benefits of public health interventions.

Practitioners can respond to public health information as well provide it. For example, research may reveal that certain chemicals and physical agents cause cancer, but only many years after initial exposure. For individuals exposed to carcinogens, screening and monitoring may save their lives. Bladder cancers caused by azo dye exposures in the textile industry, as an example, can often be cured if detected early. None of the health care reform proposals yet incorporates a systematic way to identify, contact and offer early treatment to all those at risk. No plan yet contemplates making health plans a clinical arm of the public health departments. At best, plans will be graded for their success in providing preventive services, such as pap smears, to everyone in the plan for whom the test is appropriate.

Optimal public health gains will be more difficult to achieve if populations remain outside the reformed medical care system, that is, if they are not enrolled. From the public health point of view, a policy decision to leave some individuals outside the health care system does not remove their contribution to health or disease in the United States. Yet Congress is already debating just how *universal* health care reform should be, further evidence that medical care's role

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9 Thanks to Michael Osterholm, Ph.D., State Epidemiologist, Minnesota Department of Health, for this vivid analogy between fire fighting and public health.

in public health is being ignored. If the Congress chooses to limit insurance for health services to some categories of residents, its members should recognize that there is no economic or health justification for withholding payment and limiting access for those measures which protect the community from the spread of preventable problems.

The precise list of the services for delivery to populations at risk and to populations posing risks to others can be argued about and revised over time as health conditions change and knowledge grows. Similarly, the specific data needed from providers to bolster epidemiological information systems and research will evolve. But all these activities which unify public health and medical practice into an effective and efficient health care system cannot be grafted onto reform after organizational, management and financing mechanisms have been legislated. Instead, the overall design needs to contemplate how to use enrollment, management and finance components as incentives, checks and balances to improve performance and health.

Most proposals appear to isolate public health from health care. They separate medical care spending from the annual federal and state budgets while leaving public health at the mercy of annual Congressional and state appropriations, where they compete under a spending cap against other popular programs. In the 95th Congress, Senator Robert Stafford of Vermont understood the problem, and proposed to establish minimal standards for public health programs before legislating national health insurance.[10] The requirement was intended to protect public health programs from the pervasive conviction that national health insurance would solve all health problems, including those traditionally in the domain of public health. But no system of national health insurance was enacted in the 1970's and the Department of Health and Human Services (DHHS) never made a serious attempt to develop standards to protect public health programs. While Senator Stafford's contribution remains on the books, it has no practical value in the absence of a standard setting process within DHHS and the political will to make federal funds or participation in a national insurance scheme contingent upon meeting the standards for state public health programs.

In the absence of structural modification of reform legislation, the political process is likely to repeat the costly mistake of providing chronically insufficient and unstable support for the core public health functions, leaving them on the fringe of the medical care system rather than developing an integrated national system capable of vast efficiencies in the use of medical resources.

When the World Bank evaluated investments that improve health, public health interventions were repeatedly more cost effective than medical services. Even if not all members of the Congress and of state legislatures are familiar with the World Bank's well documented analysis of national health systems around

[10] Robert Stafford introduced S. 48, "A bill to provide for minimum standards for public health programs directed at identifiable populations" on 10 January 1977. On 1 August 1977, the 95th Congress enacted legislation, P. L. 95-83, that incorporated Stafford's bill, directing the Secretary of Health, Education and Welfare to develop "model standards."

the world, the drafters of reform proposals should be.[11] The *1993 World Development Report* shows that the United States elicits extraordinarily low health value for the economic investment in health services.

Public Health Authority -- a Neglected Foundation for Reform

The need to protect the health of the public will not disappear with health care reform. Public health authority will still exist in the states. To protect the public, states should be able to harness the medical care system's highly trained workforce, capable laboratories, linked records system, and billions of contacts with the population.

Authority to regulate human behavior to avoid harm and to enhance health, called the "police power," is contained in Article X of the United States Constitution. The framers included this power among those "not delegated to the United States by the Constitution, nor prohibited by it to the states" thus among those "reserved to the states respectively, or to the people."[12]

States began establishing authority in boards of health more than a century ago and expanded their activities through state and local health departments. Quarantine of people capable of spreading communicable diseases, searches of housing, restaurants and factories for health hazards, seizures of dangerously mislabeled goods, injunctions to refrain from or engage in certain acts, and licensure of practitioners and of facilities to enforce minimum standards of practice have all been sanctioned by courts as legitimate efforts to protect the public's health.

A measure of federal health regulation began early under the "commerce clause" of the Constitution.[13] Federal interventions in health have expanded in this century. Food and drug laws, worker, environmental and consumer protections have invoked federal preemption of state authority. Many federal health programs offer grants and financial incentives to the states. The dominant force is financial assistance under the Social Security and Public Health Service Acts to encourage states to expand services for special populations such as children, the poor, the elderly and migrant workers.

In many state health departments, federal programs and funding for providing personal services to specific populations have overwhelmed maintenance of core public health functions and regulatory activities. Even as Presidents Reagan and Bush reduced federal funds for domestic programs, states increasingly structured their health and welfare programs to capture remaining federal funds. Medicaid, known throughout the recession in 1980's as the "budget buster," induced many state health departments to rebuild

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11 World Bank, World Development Report 1993: Investing in Health (New York: Oxford University Press).

12 Constitution, art. X.

13 A statute gave federal agents authority to detain merchant seamen in quarantine when they were thought to be carriers of dangerous infections; the seamen were provided medical care under the same statute.

population-oriented programs into fee-for-service offerings. In so doing, public health administrators, who at an earlier time in history might have been more cognizant of the fundamental role of the state to protect the health of the entire population, became modern managers of medical care for the poor, judged by governors and legislators for their success in reducing state spending and in maximizing the federal contribution. This neglect of public health could worsen with health care reform.[14]

No one asserts that states can protect the public's health without assistance. The tools for improving public health, such as surveillance and information systems, research and development for new diagnostic tests, vaccines and therapies depend on national investment and coordination. Health care reform must assure continued support for the National Institutes of Health, the Centers for Disease Control, the Food and Drug Administration, and programs at the Department of Labor and Environmental Protection Agency created to protect the public health. Yet no health care reform proposal explicitly takes advantage of state public health authority and the federal institutions that support it. Where private medical service providers deliver the bulk of services, public health officials should remember that the states have the Constitutional authority to define the public health and to regulate providers to protect the public health. Where the incentives in the medical care system prove insufficient to protect the public health, states can and should insist on effective and efficient use of resources.

The federal government has resources essential to helping states meet the public health and medical needs of their residents. Federal programs in the Public Health Service should retain and expand their roles in setting health goals for the nation. New federal legislation should allocate a proportion of medical care funds to states for core public health functions and use the federal guidelines to assure compatible data collection, epidemiological research and reporting systems--and sufficient scope of effort and competence to provide the basis for holding medical practices accountable to public health goals.

Reform legislation should reaffirm the states' Constitutional power to protect the public health, giving them the needed financial and managerial leverage to use the restructured health care system, including its private sector participants, to reach public health objectives. States should translate national health targets into local ones and assist medical practices to improve and contribute to statewide and national gains. Beyond management systems and rewards the states will need to use their public health authority to regulate medical practice. When attempting to alter physician behavior, it is "especially important that physicians perceive the proposed changes as beneficial to patients (or at least not harmful)."[15] Thus it will be particularly important for public health

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[14] Anthony Robbins, "The Threat of National Health Insurance to Preventive Programs" in New England Journal of Medicine (1975), 293:503. Senator Stafford cited this article when proposing public health standards in 1977.

[15] Peter J. Greco, M.D. and John M. Eisenberg, M.D., "Changing Physicians' Practices" in New England Journal of Medicine (21 October 1993), 329:17:1271-4.

regulation to be developed and evaluated in conjunction with the medical care system, rather than imposed from the outside.

States' primary contribution under reform will be public health leadership, technical assistance to medical providers, core public health regulatory systems, and management techniques to squeeze the most health from each medical dollar. Many health departments are unprepared in one of two ways. Some have little experience with medical services, and concentrate on health hazards in the community. The very idea that such a health department could provide wise guidance and exercise an important measure of control over medical resources may seem incredible. Other departments are principally providers of medical services for the poor and neglect broad based, strategic public health interventions. These departments seem poorly equipped to exercise regulatory control for the benefit of the whole population. But as poorly equipped as the states may be, they remain the only entities with broad public health authority. Reform architects have neglected to reinforce these powers or to propose any statutory substitute at the federal level.

Immunization

To illustrate the risks we face if we bungle health care reform and to suggest the shape of a solution, we look at immunization, a challenge President Clinton is already confronting. We describe how the basic public health authority of states can be used to make medical services achieve public health objectives. Failures and subsequent success in the United Kingdom suggest that it will be possible, even before National Health Care Reform is enacted, to know whether the Clinton Administration and Congress have recognized the public health element.

Immunization fits perfectly into a reformed medical care system. It is a personal health service, like diagnosis or treatment, but is best understood as a public health strategy to reduce the burden of treatment costs and of disease for society as a whole. If, as our nation designs health care reform, we fail to require that public health interventions like immunization reduce the burden of disease, we will pay for avoidable doctor and hospital visits and escalate the tension around rationing of medical care for the ill.[16]

A fundamental difference separates public health programs prescribed for populations from decisions of individuals to seek treatment. Immunization, for example, generates greatest savings only when it is applied so completely that disease outbreaks are averted altogether.[17] Short of "herd immunity" (a high

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16 For a complete analysis of U.S. immunization programs and their failure to achieve and maintain "herd immunity," see P. Freeman, K. Johnson and J. Babcock, "A Health Challenge for the States: Achieving Full Benefit of Childhood Immunization," An Occasional Paper, John W. McCormack Institute of Public Affairs (Boston: University of Massachusetts, February 1993).

17 Unpublished reports prepared by the Medical Technology Assessment and Policy Research Center for the National Immunization Program, Centers for Disease Control, indicate that up to $16.30 in direct costs is saved per dollar spent (for MMR), and a comprehensive immunization strategy integrating every recommended immunization given on time reaps a cost savings of

level of immunity in the population that reduces disease transmission) the unprotected--unvaccinated individuals and those in whom vaccine failed to stimulate immunity--remain vulnerable.

Historical lessons about immunization, starting with Edward Jenner, the inventor of the vaccine against smallpox, should guide reform. Jenner realized that simply administering vaccine to patients seeking medical care would not fulfill his dream of global eradication. Although Jenner understood them intuitively in 1796, two lessons need to be relearned: First, only systematic immunization of entire populations protects society from epidemics. Second, however central the role played by medical practitioners in administering vaccines, an explicit, population based strategy must exist to assure participation by physicians and immunization of *everyone* who may be at risk. No society has achieved the public health benefit of vaccines simply by waiting for individuals to seek immunization, even where "access" and payment were guaranteed.

In 1979 the US. Public Health Service set national goals, asking each state to increase immunization rates for children from 60 to at least 90%.[18] A crucial element of the strategy was federal pressure on states to enact and enforce laws requiring full immunization before a child can enter school. The striking operational success of this first systematic program, measured by the number of children fully immunized at school entry, masked a design failure revealed in the 1980's. The initial strategy focused on school age children whose immunization status could be checked on their first day in school. There was no comparable "check point" or enforcement plan for younger children who were not entering school.

About half of preschool children, especially those aged 0-2, remained incompletely immunized. A measles epidemic in 1989-91 brought the error of omission to the front pages of American newspapers. The US. Public Health Service acknowledged that a two-year epidemic had resulted in more than 55,000 reported cases of measles, more than 130 measles-related deaths and 11,000 hospitalizations.[19] President Clinton estimated the hospital costs alone at $20 million for an epidemic that $1 million worth of public health could have prevented.[20] If past experience holds, for every measles death there will be three additional children with permanent brain damage who will continue to add costs

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$7.60 per dollar spent. See E. Hatziandreu, C. S. Palmer, R. E. Brown and M. T. Halpern, "Cost Benefit Analysis of DPT Vaccine," (19 January 1994); E. Hatziandreu, R. E. Brown and M. T. Halpern, "Cost Benefit Analysis of MMR Vaccine," (25 January 1994); and E. Hatziandreu, C. S. Palmer, M. T. Halpern and R. E. Brown, "Cost Benefit Analysis of OPV," (8 February 1994). Cost savings of vaccine use are even higher when indirect costs such as lost workdays are considered.

18 Public Health Service, "Healthy People: Surgeon General's Report on Health Promotion and Disease Prevention," Washington, D.C.: U. S. Department of Health and Human Services (1979).

19 U. S. Department of Health and Human Services, Public Health Service, Morbidity and Mortality Weekly Report (4 February 1994), 58.

20 Speech by William Jefferson Clinton at Fenwick Center, Arlington County Department of Human Services, Arlington, Virginia (12 February 1993).

to the medical care system throughout their lives.[21] The epidemic was diagnosed as due to failure to immunize preschool children on time.[22]

For immunization monitored at school entry, public health agencies could rely on practitioners and clinics to immunize children identified to need vaccine. Without a tracking and notification system to alert health authorities and families for each immunization visit, there was no population based accountability for infants and toddlers, as at school entry. In the 1980's diminished federal public health funding, increasing vaccine prices, and increasing demand on public clinics compounded the problem. Even families who sought immunizations for their preschoolers could not always find them.

A reformed medical care system could cure these flaws and assure timely immunization of preschoolers (and adults, too), but only if practitioners are held accountable to a national public health strategy. Every American must be guaranteed payment for services and a regular place to seek them. Moreover every person should be enrolled in a medical plan or practice which can be held responsible for the results--full and timely immunization of all enrollees. The difference between guaranteed "access" to medical care for those who seek it and accountability of medical practices to public health authorities to render services that may never be sought by the consumer is decisive. Bearing the distinction in mind, immunization is not the only public health service which can make use of a reformed medical care system.

When delivery of vaccines is fully integrated into a universal medical care program, public health support will be required as much as ever. We must assure that cases of vaccine preventable disease are reported to public health authorities so that vaccine failures can be detected and flaws in the delivery system investigated and remedied. Disease surveillance based on competent laboratories will be needed to detect emerging and re-emerging infections. Our capacity to vaccinate with safe and effective vaccines will also depend on government research and development, and regulation. As a public health tool and because they have usually provided less return on investment than pharmaceuticals, vaccines are unlikely to attract sufficient investment without government assistance.

It is not clear that health care reformers understand the difference between clinical and public health laboratories and no reform proposal acknowledges the difference or incorporates the public health function in its scheme. Public health laboratories perform tests to determine threats to the population even if there will be no diagnostic or therapeutic benefit to the individual from whom a sample was drawn. For example, we now have an effective vaccine for H flu type B, a disease which causes meningitis, predominantly in young children. When the vaccine was introduced in the state of Massachusetts it reduced the incidence of

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21 Stephen R. Preblud, M.D. and Samuel L. Katz, M.D., "Measles Vaccine" in Stanley A. Plotkin and Edward A. Mortimer, Jr., eds., Vaccines (Philadelphia: Harcourt Brace Jovanovich, Inc., W. B. Saunders Company, 1988), 183.

22 National Vaccine Advisory Committee, "The Measles Epidemic: The Problems, Barriers and Recommendations" in Journal of the American Medical Association, 266:11:1547-52.

the disease by 70% in the first year. Similar results have occurred wherever the vaccine has been delivered universally.

There is no vaccine for other types of H flu, or for the non-typeable strains which also may cause invasive disease. With increased use of the H flu type B vaccine the relative importance of the other types and non-typeable strains is increasing as public health officials attempt to distinguish disease caused by strains against which there is no vaccine from failures of the vaccine to protect immunized children against type B. Similarly it is laboratory testing which allows public health officials to identify outbreaks which can be quelled by immunizing children who may have missed one or all doses of the type B vaccine.

Because there may be no clinical benefit to the individual patient to determine the particular strain, many clinical laboratories do not perform the tests. In the absence of a funded public health laboratory or of public funds to pay a clinical lab for this function, the lab may bill the patient or the patient's insurer, either of whom may refuse to pay the claim because the typing test does not enhance treatment. With increasing emphasis on cost containment clinical labs are likely to avoid such testing. But most medical care reformers have not appreciated the distinction nor have they made provision to assure that technically competent laboratories handle public health testing--and guarantee remuneration. Public health officials also worry that cost-conscious physicians concerned only with their individual patients may not think to order these kinds of tests or to provide samples to their colleagues in public health laboratories. Many states are doing less of this testing as appropriations shrink--or are less equipped to produce reliable results as the technology available in public facilities lags behind the clinical labs.

United Kingdom Experience

Should one doubt that attention to public health strategies is needed when planning health care reform, consider the history of immunization in Britain. Failure of public health authorities to intervene in the National Health Service and of medical practitioners to practice public health subjected Britons to 40 years of unnecessary exposure to vaccine preventable disease.

The British adopted their version of national health care reform in 1947 by establishing the National Health Service. Its designers made the erroneous assumption that universal access to and payment for medical services would suffice. It took forty-four years before they understood the flaw in their original blueprint and were able to correct it. We need not replicate that misjudgment.

Since 1947 basic medical services in England have been provided by general practitioners, salaried by the National Health Service. Since the start every child was on the list of a general practitioner paid and equipped to provide recommended immunizations. The vaccines were available free to doctor and patient which eased the process. Even so in the 1960's, children unimmunized against pertussis fueled the spread of a frightening epidemic disease. Whooping

cough outbreaks were evident in hospital admission rates. How was this happening with universal, fully paid access to medical services?

The answer was almost too simple: medical practitioners left to their own devices were not very good at public health. Even where they administered vaccines to children whose families sought them at appropriate intervals, physicians did not seek out all those on their lists who came in late or not at all. Doctors saw only the individual child, rarely encountering the broader consequences of missed immunizations. In the absence of data showing that practitioners were giving preventive services principally to patients who sought them, never reaching many who remained at risk, epidemic pertussis erupted before health authorities knew national rates of immunization were too low to maintain herd immunity. Even assigning every child to a doctor had not guaranteed high levels of immunization coverage.

Belatedly the national public health agency (Department of Health) asserted leadership and enlisted the medical care system (National Health Service) in a joint effort to avert further epidemics. In April 1990 the Department set targets and reviews for all levels of operation of the NHS. This time they assured good results.[23]

By 1991 immunization coverage in England rose from a national average of approximately 70% to an unprecedented high of 90% for children in every age group. The remarkable and swift success is credited to a public health strategy adopted by the medical care system. Its elements include: 1) setting numerical targets nationally and at every level down to the individual practitioner; 2) appointing immunization coordinators in every health district; 3) using computers extensively for appointments, recall, and identification of defaulters; 4) simplifying the immunization schedule; 5) issuing immunization guidelines that progressively narrowed the acceptable medical reasons for withholding vaccine from a child, and 6) changing the payment system to establish significant incentives to the providers to seek out their patients to reach the new targets.[24] Surveillance for vaccine preventable disease has also been a priority in the U.K. The Department of Health has participated in the development of a rapid field diagnostic test for measles. When fully tested the diagnostic kit will be provided to practitioners in the National Health Service.[25]

Although all of the elements were significant in achieving success, the imposition of incentive payments was the most radical departure from custom--and perhaps the essential feature of success. The United Kingdom long ago stopped paying general practitioners on a fee for service basis. They also discontinued capitation payments for immunization. Instead, they divided compensation for immunization into two payments. Every physician

23 David Salisbury, "The Immunization Program in England" in Proceedings of the 25th National Immunization Conference, Washington, D. C., June, 1991 (Atlanta: Centers for Disease Control), 51.

24 Ibid., 49.

25 David Salisbury, personal communication, 28-9 September 1993.

administering immunizations is now paid the amount that same practitioner would have received for achieving the national average of 70% coverage under the old capitation program. Second, each physician who meets the new target level is paid a substantial bonus. No bonus payments are made to any physician who falls short of reaching the target.

Because success was so impressive, new target levels have been set to raise coverage levels to 95% of all children.[26] British public health authorities have made doctors a contributing part of the national immunization effort and today no one suggests that a separate public health program is required to achieve universal childhood immunization as public health guidance and support has purposefully been integrated into daily medical practice.

Childhood immunization is a powerful example, but other public health objectives can be realized as well -- if we articulate the strategy and assign to the medical services delivery system those tasks its medical practitioners can perform most effectively and efficiently. Together, federal government and the states should build a system in which:

- Medical services providers detect, obtain necessary laboratory confirmation[27] and report cases of disease in a prescribed manner, helping public health inspectors and investigators find and control sources of exposure in the community.

- Medical services providers respond promptly with early diagnostic testing and treatment when individuals at high risk (or their characteristics) are identified by public health workers in the community.

- Medical service providers reach every member of the population who can benefit individually or where "treatments" are needed to protect others.

- Medical services providers know if their interventions are succeeding and if new or different health problems threaten our people.

Conclusion

Our expanded prescription would require the reformed medical care system to perform certain functions systematically that in the past have been optional for medical practitioners or left to health departments by default. The challenge to reformers is to rebuild the core public health capacity of the states to create a competent national system; and to assure that the medical services that we will pay for under health care reform perform certain functions critical to the health of the public. How can we know that the reformers are incorporating every

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26 Salisbury, "The Immunization Program in England," 51.

27 This includes laboratory confirmation essential not only for diagnosis and treatment of individual patients, but also to identify the presence of new pathogens, or increasing incidence of those thought to be waning or of little significance to public health because they were not known to cause serious disease.

intervention that can improve health and hold off unnecessary expenditures? Do they have a thorough analysis of how medical services will contribute to public health? And if so, does their analysis indicate which of these services require assistance and guidance from public health departments? Have they made sure in each instance to allocate resources for the public health component as well as for medical services?.

Our advice is not new, but it is timely. Seventy-five years ago, a warning about inattention to public health agencies was issued to the Medical and Chirugical Faculty of Maryland. It must be heeded today as we reform medical care:

> "With the appropriations for health insurance running into millions of dollars annually it goes without saying that legislative bodies will not materially increase the appropriations for their health departments. Owing to this fact, there is a decided probability of sickness insurance acts endangering the very existence of State health departments by absorbing all of the funds available for health work. Our statesmen and lawmakers must, therefore, be careful that proper and ample provisions are made for health machinery in any sickness insurance act."[28]

28 B. S. Warren and E. Sydenstricker, "Health Insurance, the Medical Profession and the Public Health" in Public Health Reports (1919) 34:16:775-89.

Bibliography

Centers for Disease Control. 1994. Addressing emerging infectious disease threats: A strategy for the United States. Atlanta: Centers for Disease Control. In press.

Freeman, P., K. Johnson and J. Babcock. 1993. A health challenge for the states: Achieving full benefit of childhood immunization. An Occasional Paper, John W. McCormack Institute of Public Affairs. Boston: University of Massachusetts (February).

Greco, Peter J. and John M. Eisenberg. 1993. Changing physicians' practices. New England Journal of Medicine (21 October), 329:17:1271-4.

Hatziandreu, E., R. E. Brown and M. T. Halpern. 1994. Cost benefit analysis of MMR vaccine. Medical Technology Assessment and Policy Research Center. Report prepared for the National Immunization Program. Atlanta: Centers for Disease Control (25 January). Unpublished.

Hatziandreu, E., C. S. Palmer, R. E. Brown and M. T. Halpern. 1994. Cost benefit anlysis of DPT vaccine. Medical Technology Assessment and Policy Research Center. Report prepared for the National Immunization Program. Atlanta: Centers for Disease Control (19 January). Unpublished.

Hatziandreu, E., C. S. Palmer, M. T. Halpern and R. E. Brown. 1994. Cost benefit analysis of OPV. Medical Technology Assessment and Policy Research Center. Report prepared for the National Immunization Program. Atlanta: Centers for Disease Control (8 February). Unpublished.

Himmelstein, D. U. and S. Woolhandler. 1992. The national health program chartbook. Cambridge: The Center for National Health Program Studies.

National Vaccine Advisory Committee. 1991. The measles epidemic: The problems, barriers and recommendations. Journal of the American Medical Association, 266:11:1547-52.

Preblud, Stephen R. and Samuel L. Katz. 1988. Measles vaccine. In Stanley A. Plotkin and Edward A. Mortimer, Jr., eds., Vaccines, 182-222. Philadelphia: Harcourt Brace Jovanovich, Inc., W. B. Saunders Company.

Robbins, Anthony. 1975. The threat of national health insurance to preventive programs. New England Journal of Medicine, 293:503.

Salisbury, David. 1991. The immunization program in England. Proceedings of the 25th National Immunization Conference, Washington, D. C. (June). Atlanta: Centers for Disease Control.

U. S. Department of Health and Human Services, Public Health Service. 1994. Morbidity and Mortality Weekly Report. Washington, D.C. : U. S. Department of Health and Human Services (4 February).

_____. 1979. Healthy people: Surgeon General's report on health promotion and disease prevention. Washington, D. C.: U. S. Department of Health and Human Services.

Warren, B. S. and E. Sydenstricker. 1919. Health insurance, the medical profession and the public health. Public Health Reports, 34:16:775-89.

White House Domestic Policy Council. 1993. The president's health security plan. New York: Times Books, Random House.

World Bank. 1993. World development report 1993: Investing in health. New York: Oxford University Press.

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Please see cc:Mail

Dolf M.

RECEIVED
4 1994
MAR 14 1994

National Healthcare Operations
U.S. Pharmaceuticals Group
Pfizer Inc
235 East 42nd Street
New York, NY 10017-5755
Tel 212 573 2066 Fax 212 573 5434

National Healthcare Operations

Richard J. Vastola
Manager—Industry Affairs

Dear Pharmacist/Physician:

Pfizer has reintroduced its antibiotic Streptomycin (Streptomycin Sulfate Injection USP), at the request of the FDA, as a key additional medicine in the treatment of tuberculosis and other labeled indications.

To enroll a patient in the Pfizer Streptomycin program the following information must be provided:

1) Patient's name.

2) Physician's name.

3) The medical reason(s) why a patient must receive streptomycin therapy.

4) A prescription made out for the patient, if the streptomycin is being sent to a private physician's office.

You may fax this information to 1-800-251-4445 to facilitate an expeditious turn-around time, or you may mail this request to the following address if this is not a rush request:

Richard Vastola
Pfizer Pharmaceuticals
Streptomycin Program
235 East 42nd Street
New York, NY 10017

Due to the critical supply of streptomycin, the drug is being released on a patient-specific basis. The medical reasons for the use of streptomycin insures that the drug is released for FDA approved uses.

A toll free hot line is available to answer any further questions regarding the program specifics. The number is 1-800-254-4445.

Sincerely,

Richard Vastola

Bob informed me that the problem at FDA has been resolved. Martin Delaney was called and is OK with the reduction.

SS.

talked to Martin 3/17

Office of the National AIDS Policy Coordinato

Executive Office of the President
750 17th Street, N.W. Suite 1060
Washington, D.C. 20500

Phone: (202)632-1090
Fax: (202)632-1096

Deliver To: Bob Jackson / Terry Besmick

Sent From:

✓ **W. STEVE LEE, EXECUTIVE ASSISTANT**

Number of Pages: 11 + Cover Fax Number: 6907560 Date: 3/11

Message:

Rush— Follow-up with FDA. Ahrè may know something to.
Call me upon receipt

Bob
Bad copy / typ

John F. Vanyai
3450 N. Lake Shore Dr. #2301
Chicago, IL 60657
(312) 935-7959

Steve - VI
her office to see
if they want her
on Monday —
W 3/14

RECEIVED
MAR 14 1994

Mrs. Hillary Rodham Clinton
The White House
1600 Pennsylvania Ave.
Washington, D.C. 20500

Dear Mrs. Rodham Clinton:

Although you do not know me, I am certain you are familiar with my situation. I am a 30 year-old man diagnosed with AIDS, complicated by Hodgkin's lymphoma and CMV retintis. I was first hospitalized for an AIDS-related infection in October 1989. Since then I have followed the general medical protocol, from using AZT to DDC. I have also ventured on my own by using numerous unapproved treatments. Some of these were organized through legitimate FDA-approved clinical trials; others were obtained through the still largely unrecognized buyers' clubs specializing in AIDS therapies. Amazingly, I have remained fairly healthy since my successful treatment for Hodgkins disease, which ended in June 1993.

Unfortunately, in August I was diagnosed with CMV retinitis in both eyes. Aggressive treatment with Gancyclovir was initiated and was able to stop the progression to blindness. After approximately six weeks the CMV once again became active and treatment with Foscavir, a more toxic medication, replaced the Gancyclovir treatment. After the initial success of the Foscavir, the CMV once again became active. The only remaining recognized therapy was concurrent Gancyclovir and Foscavir treatment. This line of therapy has also been unsuccessful, and my vision continues to deteriorate despite three daily intravenous infusions of these medications. Matters were also complicated by the detachment of the retinas in both eyes, requiring a vitrectomy in each eye to restore what little sight I have left. Throughout my battle with HIV I have always remained as up-to-date as possible on new or successful treatment options. Along with my doctors, I had finally reached a dead end which would definitely lead to total blindness and, ultimately, my death.

A new ray of hope entered my life when I discovered there was one available treatment that might potentially delay or prevent my progression to total blindness. I was infuriated to learn that this treatment was already FDA-approved for use in CMV disease in a select group of patients. These individuals' immune systems had been lowered to allow for successful kidney transplantation. During conversations with medical personnel employed by the drug's manufacturer, I learned that there were no plans to test this treatment in AIDS patients with CMV disease. Needless to say, no formalized efficacy trials have ever been conducted, to their knowledge. After discussing with my physician the possible side effects of this drug, called Cytogam, we chose to begin treatment immediately. Since the treatment had not been tested in in formal clinical trials, my insurance carrier refused to treat the expense as covered in my medial insurance policy. The only supportive information I was able to gather was strictly anecdotal.

The most alarming factor of this impending treatment was its cost. Based on wholesale prices of the medication and the necessary infusion supplies, the first month's induction treatment would cost nearly $10,000. I was able to negotiate this price, which was at cost, through my home health care company. This meant that I was required to pay, in advance, $9,100.00 in order to have the medication delivered to me and be trained on its infusion at home. I applied this charge toward my VISA credit card. It was then that I was informed that I would be required to pay cash on delivery for all future treatments, unless my insurance carrier reconsidered its decision.

I have contacted the Chicago branch of the AIDS Legal Council for assistance. Unfortunately, they have been unable to locate an attorney willing to accept my case on a pro bono basis. As you can imagine, I am unable to pay attorneys' fees and court costs. I will also be unable to continue paying Cytogam maintenance costs, which are approximately $5,400.00 per month.

You may be pleasantly surprised to hear that my overall health has significantly improved since I began receiving treatment with Cytogam. I have gained approximately 15 pounds. My stomach pains have subsided. My blood counts have stabilized, and my overall attitude has significantly improved. I am unable to say that my retinitis has improved. However, I can say that my vision has remained stable with significantly fewer flashes of light. All three of my physicians feel confident that these changes must be the result of the Cytogam treatment, as no other changes have been made in the treatment regimen.

I am appealing to you for a number of reasons, the first of which is to enlighten you on the various struggles that individuals who are ill are forced to undertake when attempting to save their lives. That is not the time to focus your energy on fighting for what you as an individual deserve. Rather, your focus should be on improving your health and remaining a productive part of society rather than a financial drain. I am also appealing to you as an individual hoping that, as the First Lady of our country, perhaps there is something that you can do to assist me at this crucial point in my life. Financially, within the next few months I will be unable to pay for future treatments. In essence, I am being asked to choose between saving the precious sight I have left and even my life, and paying for medical treatment I cannot afford. I had been taught to plan all aspects of my future from a very early age. I was always taught to continue my education and also prepare for the unexpected which may occur at any time. I have done so by maintaining excellent disability and medical coverage. However, I now find myself unable to rely upon these conventional providers of support. In the end, it all becomes a matter of how much money one has. I am appealing to you to see if there is something you would be able to do in this individual case. I am also hoping that what I have described will assist you and President Clinton in designing a health-care system that is fair and equitable and focuses not strictly on maintaining life, but maintaining a quality of life beneficial to oneself and society.

I would greatly appreciate the opportunity to discuss the matter with you in greater detail. Due to the urgency of the situation, I hope you can find the time to contact me soon, while the matter is still relevant.

Sincerely ,

John Vanyai

cc. President Wm. Clinton
David A. Kessler, M.D., FDA Commissioner
Christine Gebbie, National AIDS Policy, Coordinator
Susan Curry, AIDS Legal Council of Chicago
Thomas Eder, President, Thomson Financial Publishing
T. Emmett Dages, CFO, Thomson Financial Publishing

United States Department of State

Bureau of Oceans and International Environmental and Scientific Affairs

Washington, D.C. 20520

FACSIMILE

Pages to follow 1

TO: Distribution

FROM: Ed Malloy, Director, Office of Science, Technology and Health

SUBJECT: First meeting of Diplomacy Working Group: International AIDS Strategy Development

MESSAGE:

The Diplomacy group will meet in Room 7835 of the State Department on Thursday, March 24th, from 1:30 - 2:30. We welcome participation by all interested individuals and encourage participation by the chairpersons of the other groups.

We plan to open the meeting with brief summaries of the progress of the other groups involved in this effort. We expect that these summaries will highlight the major concerns of each group, including obstacles in each thematic group which impede progress in stemming the spread of global HIV/AIDS and gaps in policy. We will then focus on the mechanisms available for addressing the concerns and possibly implementing the recommendations raised in the each of the other groups.

Please call Sharon Hemond at 647-4537 if you plan to attend so that we may arrange for your clearance into the State Department's "C" Street entrance.

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. fax	re: Interagency Group - Development of HIV/AIDS Strategy; [Partial] (1 page)	03/18/1994	P3/b(3)

COLLECTION:
Clinton Presidential Records
National AIDS Policy Office
Kristine Gebbie
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FOLDER TITLE:
[Miscellaneous Memos and Correspondence - 1994] [loose] [3]

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b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Distribution:

Interagency group - Development of HIV/AIDS strategy

	phone	fax
(b)(3)		
Mark Hunter, DOL/OASP	202-219-6197	219-9216
Kristine Gebbie, White House	202-632-1090	632-1096
Nancy Hazleton, EOP/ONAP	202-690-5560	690-7560
Shelley Smith, Peace Corps	202-606-3765	606-3024
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Donald S. Burke, US Army	301-295-6414	295-6422
Shirley Jackson, Ed/OERI	202-219-2218	219-1402
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Prudence Bushnell, DOS/AF	202-647-4493	647-6301
Faith Mitchell, DOS/RP/POP	202-647-9718	647-8162
Sandra O'Leary, DOS/EAP	202-647-6904	647-7350
Sharon Hemond, DOS/OES/STH	202-647-4537	736-7336
Rich Bruno, DOS/OES/STH	202-647-9542	736-7351
Anthony Phipps, DOC	202-	482-0432
Allan Hinman, DHHS/PHS/CDC	404-	639-8600
George Walter, EOP/NAPO		632-1096

[001]

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THE WHITE HOUSE

WASHINGTON

March 21, 1994

VIA FAX:401-2098
2 pages total

MEMORANDUM TO SECRETARY RICHARD RILEY

FROM: Kristine M. Gebbie, R.N., M.N.
National AIDS Policy Coordinator

SUBJECT: H.R. 6 amendments

The attached letter to Representative Unsoeld was requested so help support the floor fight tonight against the amendments to limit health education curriculum. I sincerely hope that you can weigh in very strongly with your own letter. I did get to see the March 1 Statement of Administration Policy on this matter, but additional letters of support surely help in these floor fights on such highly charged emotional issues.

If you have any questions or comments, please contact me at 632-1090. Thank you.

THE WHITE HOUSE

WASHINGTON

March 21, 1994

Dear Representative Unsoeld:

I would like to weigh in with you on my support for HR 6 and to convey my concern regarding any amendments that would restrict the ability of local communities to make their own decision about school-based health education and health services programs.

AIDS is one of our greatest national crises. Adolescents are the greatest population at risk for HIV infection. Schools need to provide comprehensive health education, that includes AIDS prevention education, and meets the needs of local communities. Tying the hands of local education officials will only put into jeopardy our efforts to help children and their families make healthy choices in their lives. I applaud your efforts to fight off any amendments that would effect the health of our children and hope that you will loudly oppose these amendments.

Thank you.

Sincerely,

Kristine M. Gebbie, R.N., M.N.
National AIDS Policy Coordinator

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

March 1, 1994
(House)

STATEMENT OF ADMINISTRATION POLICY

(THIS STATEMENT HAS BEEN COORDINATED BY OMB WITH THE CONCERNED AGENCIES.)

H.R. 6 - Improving America's Schools Act of 1993
(Kildee (D) MI and 38 others)

The Administration supports House passage of H.R. 6. The bill would: (1) reauthorize and restructure the elementary and secondary education programs of the Department of Education to make them better vehicles for helping all children achieve high standards; (2) direct greater Federal resources to the poorest schools and communities; (3) support education reforms under way in the States; (4) support sustained, intensive professional development in the core academic subjects for educators; (5) assist efforts to make our schools safe and drug-free; and (6) provide increased State and local administrative flexibility, in return for greater accountability for successful education results.

Although H.R. 6 contains provisions that the Administration does not support, it is consistent with Administration objectives and, in most respects, would substantially improve current law. The Administration looks forward to working with Congress to strengthen the bill further as it moves through the legislative process.

Of the amendments that may be offered on the House floor, the Administration strongly opposes the following:

(1) The Rohrabacher amendments that would affect undocumented students and children of undocumented parents. These amendments would impose an enormous data-gathering burden on schools and conflict with the Administration's goal of holding all children to the same challenging standards. States and local school systems would continue to have the constitutional responsibility to educate undocumented children, but public schools would be denied the Federal resources available to assist them in meeting their responsibility. Finally, these amendments would likely subject citizen and legal resident children of certain ethnic backgrounds to discrimination and humiliation.

(2) Any amendments that would restrict the ability of local communities to make their own decisions about school-based health education and health services programs compatible with the needs of their children.

(3) Any amendment that would transfer funding responsibility for Impact Aid military-connected children to the Department of Defense (DOD). Such a provision would jeopardize the readiness of America's military forces and be contrary to the long-standing policy that the Department of Education finance Impact Aid for all federally connected children.

(4) The Roth amendments that would restrict or eliminate federally supported bilingual education programs. The first amendment would deprive thousands of educationally disadvantaged children of the services they need to achieve challenging educational standards. The second amendment would cut off badly needed funding to schools that are legally required to provide special services to limited English children.

Pay-As-You-Go Scoring

H.R. 6 would affect receipts; therefore, it is subject to the pay-as-you-go provisions of the Omnibus Budget Reconciliation Act of 1990. OMB's preliminary estimate is that the pay-as-you-go effect of the bill is zero.

* * * * * * *

A. Wayne Freeman
Barbara A. Freeman

2050-C Wharf Rd.
Capitola, CA 95010-2000

RECEIVED
MAR 23 1994

3/22/94

Kristine Gebbie
National AIDS Policy Coordinator

re:

Dear Ms. Gebbie:

I am writing to you to express my desire that President Clinton sign the final version of the Dietary Supplement Health and Education Act (S. 784/H.R. 1709) when it reaches his desk.

These bills are very popular with the electorate and each is co-sponsored by a majority in its respective house of Congress, yet are being held up in committee. I hope that the President can use some of his influence to get these bills out of committee and onto the floor so that the will of the people can be done.

I am a consumer of nutritional supplements, not employed in the nutritional supplement industry. I resent very much the stated desire of the FDA (recent statements notwithstanding) to remove from the market and/or limit the availability of information that I can obtain about the products I consume.

I voted for President Clinton, and wish you all the best in your efforts in his service.

Sincerely,

A. Wayne Freeman

THE WHITE HOUSE

WASHINGTON

March 30, 1994

Mr. Arthur Levitt, Chairman
Securities and Exchange Commission
450 5th Street, N.W.
Washington, DC
[VIA COURIER]

Dear Mr. Levitt:

I am writing to request your continuing approval to permit Mr. Lance Alworth to work on HIV and AIDS education issues in the workplace as part of the Office of the National AIDS Policy Coordinator team in the Executive Office of the President.

First, let me thank you for being an active contributor to the President and Administration's efforts to fight HIV and AIDS by allowing Lance to work with us over the past several months. We have been able to successfully launch a Federal Workplace AIDS Education Initiative among all of the executive departments of the Federal government. This effort was constructed and implemented under Lance's direction. We are in our first reporting cycle and, I am pleased to tell you, that both the program and Lance's direction are receiving high marks. The results of these reports will be shared with the President.

We have begun the next phase of the Initiative, moving into the establishment of activities in the balance of agencies and bureaus in the federal government. Although we have over 125 bueraus, agencies, and other levels of the executive currently involved in the effort, we fully expect that the number will double in this phase. We are also on the threshold of commencing an extension into State governments.

I am requesting that you agree to continue to allow Lance to assist us in this vital effort. Having him available to complete the intra-federal program, launch our State program, and contribute to future directions is key to assuring the Administration's success.

I am attaching a signed memorandum of agreement for the purpose of extending Lance through this period. I would appreciate your executing it and returning a copy to me. If you have questions, or would like to discuss this, please contact either Dr. Arthur Lawrence, my deputy, or myself at (202) 632-1090. Once again, many thanks for your assistance.

Sincerely yours,

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator

cc: Mr. James Wolgemuth, SEC

MEMORANDUM OF AGREEMENT
BETWEEN THE OFFICE OF THE NATIONAL AIDS POLICY COORDINATOR
AND THE U.S. SECURITIES AND EXCHANGE COMMISSION

I. PURPOSE

The purpose of this agreement is for the Securities and Exchange Commission (SEC) to provide for the temporary assignment of its employee, Mr. Lance Alworth, to the Office of the National AIDS Policy Coordinator (ONAPC).

II. BACKGROUND

The ONAPC has been designated by the President to provide government-wide leadership and direction to the Nation's efforts to combat the HIV and AIDS epidemic. The success of these efforts will require personnel possessing a broad variety of talents and experience. The National AIDS Policy Coordinator (NAPC) seeks to involvement and cooperation of each of the Federal government's Departments and independent agencies as partners in this effort. Optimal outcomes can be achieved through the temporary assignment of appropriate qualified personnel from federal operating organizations to work on projects and processes under the direction of the NAPC.

Mr. Alworth possesses broad experience and understanding of issues surrounding HIV and AIDS education. He has been active in the field of HIV and AIDS awareness for several years and is well suited to provide direction to a program to promote HIV and AIDS education within the Federal government. Mr. Alworth has demonstrated his high-level abilities in these realms by directing the development and implementation of such a program since mid-August.

III. GENERAL PROVISIONS

The SEC agrees to direct that Mr. Alworth's temporary duty station is the ONAP. During this period, he will remain an SEC employee and will be remunerated and covered by benefits in accordance with customary SEC policy. The ONAPC will cover any and all travel expenses incidental to the work which is conducted in behalf of the NAPC. ONAPC will make adjustments to travel and program schedules to accommodate periods which, from time to time, may require the employee to split his weekly work time between SEC functions and those of the ONAPC. Such schedules will be negotiated in advance. ONAPC will maintain and execute administrative documents which SEC may designate in support of the assignment.

IV. TERM OF AGREEMENT

This agreement takes effect when fully executed by both signatories and replaces any existing agreement. This agreement will be effective through August 16, 1994. The content, conditions, and/or term of this agreement can be modified at any time with the mutual written agreement of the signatories or their representative(s).

APPROVED AND ACCEPTED:

_____ Date_____

Arthur Levitt
Chairman
Securities and Exchange Commission

Kristine M Gebbie Date Apl, 1994

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator
Executive Office of the President

March 31, 1994

NOTE TO STEVE LEE



MAR 3 1 1994

The attached has been discussed with KMG. In order to finalize, it needs the following:

1. KMG needs to sign the letter.

2. KMG needs to sign the second page of the agreement.

3. Have a signed copy of each sent over to me in the inter-office.

3. The letter and attachment need to be couriered or hand carried to the SEC. The previous copy which was mailed to SEC got lost there, so it is important to assure that someone signs for this.

Call if you have any questions. Thanks.

Art

March 31, 1994

SCHEDULED INTERVIEW
FOR
KRISTINE GEBBIE
NATIONAL AIDS POLICY COORDINATOR

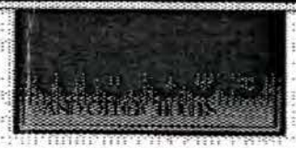
ONAPC STAFFER:	John Paul Gurrola
DATE/TIME OF EVENT:	April 1, 1994 11:00AM **[VIA TELEPHONE]**
LOCATION:	Office **[YOU CALL 404/627-8664]**
ORGANIZATION:	Faith and Health Publication
CONTACT:	Amy Green 404/627-8664
PURPOSE:	To interview the NAPC
OTHER PARTICIPANTS:	Amy Green will interview
MEDIA COVERAGE:	NONE
REMARKS REQUIRED:	Discuss how our work interacts with religious communities and other targeted groups.
BACKGROUND:	The publication is targeted at Health Care workers that are somehow involved in their faith, be it lay or ordained. The circulation is around 10,000 and they are relatively new. Please see attached copy of their latest issue.

Faith Health

Published quarterly by
The Interfaith Health Program
of The Carter Center of Emory University
One Copenhill
Atlanta, Georgia 30307

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Executive Director,
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EVERY DAY the worldwide economy burns an amount of energy the planet required 10,000 days to create. Or, put another way, 27 years' worth of stored solar energy is burned and released by utilities, cars, homes and factories, and farms every 24 hours. ... Science and common sense both declare that such extravagance must eventually lead to disaster. It not only loomes over the future, thus threatening human societies in the long term, but it also puts intense pressure on the other species in these ecological niches which depend on the same resources. —Paul Hawken, *The Ecology of Commerce*

▼

ONE ESTIMATE OF THE COST of the realistic program to combat [eliminate] hunger in the 1990s is about $8 billion a year — about $7.25 for every citizen in the affluent world. —*George Carnahan on Science, Technology and Government*

▼

PEOPLE WHO ATTEND RELIGIOUS SERVICES regularly are likely to give more generously of their time and money, not only to their congregations, but to other charities as well, than people who attend infrequently, or who do not attend at all. The 36 percent who attend weekly or nearly weekly give an average of $1,220 per household a year and volunteer 3.2 hours of their time per week, compared with $217 and 1.4 hours for those who do not attend at all. —*Hunger 1994, Fourth Annual Report on the State of World Hunger by Bread for the World Institute*

▼

THE 50 LARGEST ANTI-HUNGER organizations devote only $7.5 million each year on media relations, compared to the $1.5 billion Philip Morris spends each year promoting its products. —*Hunger 1994, Fourth Annual Report on the State of World Hunger by Bread for the World Institute*

▼

DID YOU KNOW THAT . . . ?

- 53,000 people die each year of AIDS, or about 90 people a day.
- Violence is taking about 24,000 people annually, or about 65 people a day. —Dr. J. Ehlen, *The Nation's Health*
- More than 250,000 deaths annually can be attributed to physical inactivity. —*National Center for Chronic Disease Prevention and Health Promotion*

▼

PARTLY CLOUDY . . .

During the Great American Smokeout in 1992, an estimated $17.8 million were not spent on cigarettes. —*The Tobacco Institute, 1993*

▼

IN ONE YEAR, Americans spend more on beer than the resources needed to meet these basic needs of the world's children: control the major childhood diseases; halve child malnutrition; reduce child deaths by 4 million a year; bring safe water and sanitation to all communities; provide a basic education for all children; and make family planning universally available. —*UNICEF, 1993*

▼

THE MEDIAN SALARY for specialty surgeons is currently $420,000 versus $98,000 for primary-care doctors. . . . It would take half a century to boost the number of primary-care physicians to 50 percent of all doctors. —*U.S. News and World Report*

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We welcome suggestions for articles and information. Write to the address above or call for more information: (404) 420-5151 • Fax (404) 420-5158

This publication of the Interfaith Health Program is supported by major funding from the Robert Wood Johnson Foundation.

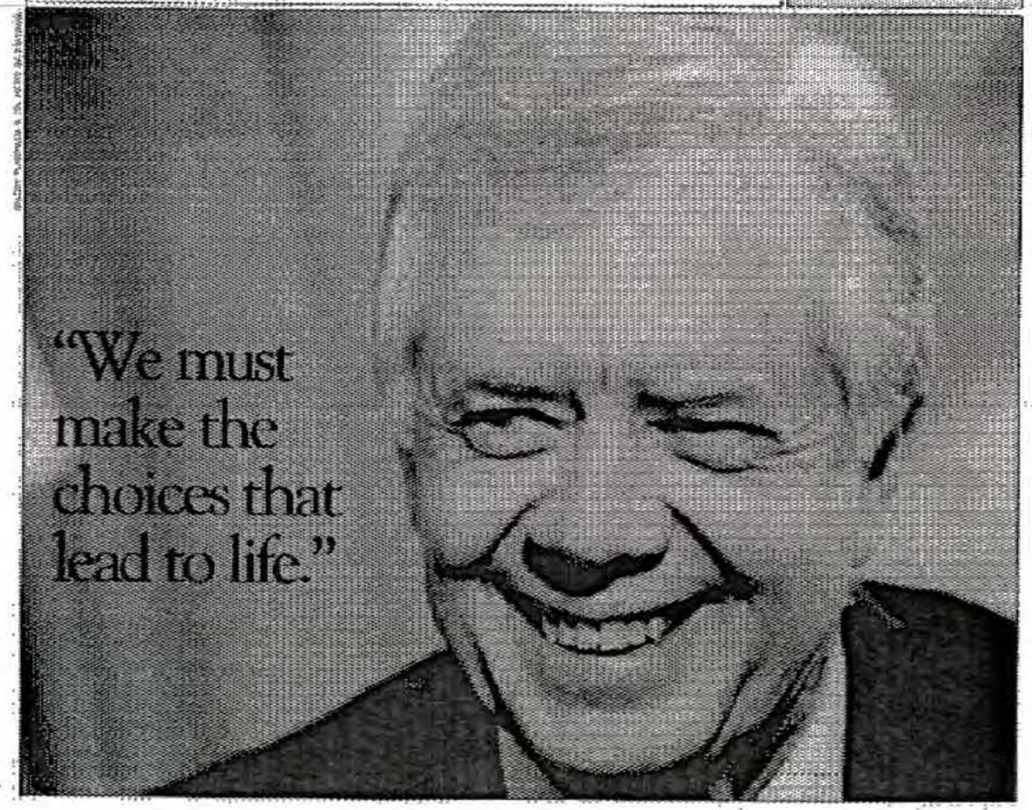
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Faith & Health

A PUBLICATION
OF THE CARTER CENTER
OF EMORY UNIVERSITY
WINTER 1994

What is the potential for faith groups in the field of health? What if your congregation merely linked with the church, mosque or temple down the street to make sure your neighborhood had adequate medical care and that every person went to bed adequately fed. Is this vision out of reach?

—Jimmy Carter



· · SENT BY:KINKO'S ; 3-31-94 ; 19:11 ; KINKO'S I ATLANTA→ ;# 8

Faith & Health

FROM FAITH IN ACTION

The Task Ahead

By GARY GUNDERSON
CEO and Associate Editor

When The Carter Center was established in 1982, its first major conference, "Closing the Gaps," explored opportunities for advances in health offered simply by applying what we already know.

The Carter Center and its affiliated organizations, Global 2000 and the Task for Child Survival and Development, are involved in health programs all over the world — immunization, river blindness, guinea worm, ecological agriculture, polio and the Internet. Mental health has been a career-long priority of Rosalynn Carter.

In 1988, The Carter Center, along with Wheatridge Ministries, convened 300 leaders from evangelical faith traditions to explore the "Church's Challenge in Health." From that meeting, which clearly defined the need for faith groups, especially acting in collaboration with each other and the public structures, to play a crucial role in human wellness, was born the Interfaith Health Program of The Carter Center.

Begun in 1993 with funding from the Robert Wood Johnson Foundation, the Interfaith Health Program intends to help mobilize faith groups toward actions that truly make a difference.

We have visited health specialists across the United States — learning their successes and their needs. We plan training events. We are developing a network for community leaders to learn from existing programs and effective colleagues. We are working collaboratively, supportively with other organizations. And quarterly, we are publishing *Faith & Health*.

The unifying commitment of all these activities is to encourage and support those leaders acting in faith and working on health.

Dr. William Foege, Carter Center fellow for health, notes that the Interfaith Health Program is conducting reverse epidemiology. Where, in the past, we ran the risk of disease, we are studying the outbreak of health. Where once we looked for early signs of pathology and the underlying pathogen, we look for active, life-enhancing, community-building and the underlying dynamic. Where we looked for interventions that can stop the spread of disease, we are committed to interventions leading to an epicenter of good health.

Faith & Health will focus on the linkages between faith and action, among faith groups working collaboratively and with public agencies, between leaders looking for the path forward and their colleagues a little further down the road.

Finally, a request: Let us know what is can be useful to you, who else we should talk to, what else we should cover.

And talk back. Dialogue is healthy, too.

What If . . . ?

By PRESIDENT JIMMY CARTER
The Carter Center of Emory University

Our generation has witnessed the impossible become possible—the death of communism, the integration of South Africa. Yet the possible—immunizing every child, eradicating illnesses caused by smoking—have proved *impossible*. Isn't it time faith became part of the health equation? What if every congregation . . . ?

We move toward the 21st Century with a vast store of knowledge and energy that have yet to be applied to the challenges of physical and mental health. Although there are many health problems for which we do not have solutions, most premature death and illnesses are actually preventable. Fully two-thirds of the years of life that are lost before age 65 could be saved by using current technology, convincing individuals to make better lifestyle choices, and drawing on the available resources already present in most communities.

Why then do average Americans spend more on health care than any other people in the history of civilization, yet remain so troubled by diseases and health risks?

Why do so many of us remain outside the reach of decent care?



PEOPLE OF FAITH know that religion sometimes is perceived as strident and divisive. Religious virtue, once synonymous with humility, is becoming confused with self-righteousness. Even while religion is being devalued, the world cries out for credible demonstrations of hope, for a competent and compassionate future.

The answer is not less faith, but more. Those of us who are part of a faith community must demonstrate that faith leads toward the service of others.

Nowhere is the need for leadership by faith groups so appropriate as in the field of health, as it draws together age-old commitments to wellness with the most current scientific insights. Health care reform and other government programs and agencies can't solve the problems alone.

Imagine what would happen if the 145 million members of faith groups in the United States served just their immediate neighborhoods. Compassion does not and should not observe such parochial limits. But even if it did, and only reached from the doors of one house of worship to the next, imagine the opportunity for service. What if your congregation joined with the church, mosque or temple down the street to ensure that, in your neighborhood, every person went to bed adequately fed, every pregnant woman had pre-natal care and every little child was immunized.

- *What if* all who sought help in their struggle with drugs or alcohol could find it?
- *What if* fear of violence were only a memory?
- *What if* every elderly or homebound neighbor were called or visited every day?
- *What if* we still had access to early medical screening and basic health promotion knowledge?
- What part of this vision is out of reach? What is too difficult, too expensive or complex? Why is this dream not a reality?

The answer, of course, is that it is all within reach. Programs to address some of these needs are operating in almost all communities. Rosalynn and I find truly remarkable local initiatives everywhere we go. This scattered mosaic of hopeful activity hints at what is possible on a larger scale.

Turning good intentions into sustained commitments requires leaders with hope and vision at every level. There is no single decision-maker who can bring good health to everyone. From the White House to the parsonage, from Congress to individual congregations, we must each make the choices that lead toward life, not just for ourselves, but for our communities.

WE HAVE WITNESSED remarkable global changes in the past decade. Communism, which we once thought unshakable, is collapsing of its own weight. Apartheid, once part of the social fabric in South Africa, lies in shreds before the determined efforts of democratic builders. Entire societies have changed their course, yet gunfire in the streets of American cities seems far more unstoppable than the Soviets ever were. Drugs seem more implacable than the most abusive South African racist.

We have not yet delivered the most rudimentary gift of modern medicine—immunization—to every child. We have not reduced the incidence of teenage smoking or successfully controlled tuberculosis.

The 1993 World Development Report noted that "health conditions around the world have improved more in the last 40 years than in all previous human history." The largest in developing countries, where life expectancy increased from 40 to 63 years, is especially dramatic. This has mostly been accomplished by the simple use of preventive measures and primary care.

It is only in hopeful communities that the small steps toward a healthy future are built, sustained and repeated over and again. This is exactly why religious people and faith groups are so crucial to the task. People of faith can recognize the linkage between the simple act of immunizing a baby and the offering of God's eternal hope to that same baby.

Life is precious. Wherever it is extended and dignified, God is honored.

FAITH GIVES US A LENS that puts the world in focus. Faith lets us see the link between the incremental and the ultimate, between the simple and the profound.

Christians, Muslims, Jews and people of all faith traditions understand what physician and author Wayne Merritt calls the struggle to: "place theology in the service of life rather than life in the service of religiosity."

In dealing with health we enrich the cycle of life that all humans share: birth, youth, mature strength, weakness and the mystery of death. If our faith does not intersect with these realities, where does it touch us at all? If it cannot move us toward compassion here, amid these basic shared human fears and hopes, what difference can we point to anywhere?

SENT BY:KINKO'S ; 3-31-94 ; 18:54 ; KINKO'S I ATLANTA→ ;# 1

we talk to smokers, we often forget their dilemma. You can't fault people for that.

What you can do is fault the tobacco companies for making addiction come true by making sure people try tobacco early enough in life that they get addicted while they are teenagers. If we could delay the first trial of tobacco until a person reaches his or her 20s, that would solve a lot of the problems.

We know that the vast majority of smokers don't want to smoke. The vast majority have tried to stop. But it usually takes multiple attempts before they succeed in quitting. So the way to approach addicts is with sympathy and with assistance.

One of the first things a congregation can do is decide that smoking is its legitimate concern. Then it can sponsor "smoke enders" clinics for anyone in the church, in the community. It turns out to be a good outreach tool, based on two things we have the science, and people want to stop. They internalize. Science and a philosophical mindset of wanting to improve the world gives religious groups power.

Q How do you get churches to act on this premise in a way that doesn't sound puritanical. How do faith groups link health and smoking issues—or other preventive practices—without sounding pious or rigid or out-of-date to people?

This, to me, is one of the great results of bringing science and religion together—you can do it on the basis of science. You don't have to do it on the basis of theology—that cause a particular. Prevention is scientifically appropriate, scientifically correct.

A good example of a group that has combined science and a social movement is MADD, "Mothers Against Drunk Drivers." That group has had more impact on the reduction of alcohol-related accidents than scientists have had, even though the scientists have had this information for a long period of time. It was a question of how to use scientific information to support a social movement.

There are obvious parallels for faith groups who have an interest in doing something health-wise. Here is an opportunity for the scientific community to provide them with a science basis for their activist inclinations.

So I think The Carter Center can offer the churches something here with our science base.

Q Healing has always been a basic tenet of most faith groups. They've built hospitals and clinics. But preventive medicine is a new approach, isn't it?

Yes. But today, it is not only the most reasonable thing to do, it's the best. It has become too expensive for them to own hospitals and clinics. It's time they looked at the other end: "How can we turn our skills to prevention." That is something faith groups can do much better than a hospital or a clinic.

That's what we at The Carter Center are working towards now: How to help faith groups do the thing they traditionally have been able to do, which is to teach people how best to live. This is the exciting 21st century mission for faith groups.

I don't mean faith groups should give up the free clinics and other programs they have to help those in need. Certainly that is an important element in the healing ministry of all faith groups.

But I also think religious groups have to remember that they have a responsibility to provide the best medicine possible.

We all get in the position of providing less than the best sometimes because we don't have the skills or the knowledge or the facilities, and in those cases you do the best you can, but you cannot use those things as an excuse that says if churches or synagogues or mosques can't afford the best, they have a license to provide inferior medicine.

Now we're asking churches to get involved in prevention, and their work has to be the very best. It's got to be as good as any health department would offer, any university—we have to meet standards.

Q Do you think we can?

Of course.

Look at how well medical schools have taught prevention—it is not a very high standard to meet.

Medical centers, medical schools and medical programs have not put their emphasis on prevention; it's a mission that escapes logic. I never have understood why public health and prevention does not get the same attention that tertiary care does. It makes no sense to keep treating people for lung cancer when you can prevent it. One-third of all cancers are totally preventable, yet look at our cancer mortality rate: it stays pretty level. That is an indictment of our society and the medical system.

Doctors have given up the preventive role partly because there is little personal satisfaction. But we tell people, you have to find a new way to get your compensations, you have to figure out how to see lives behind graphs and numbers. It is a hard thing to make this gratifying to people.

Q It is part of what faith ought to do, that is, finding satisfaction and fulfillment in preventing illness is something religious leaders ought to be able to do. They understand the importance of working toward ultimate concerns.

You are right. Leaders of faith groups can provide that motivation and that gratification.

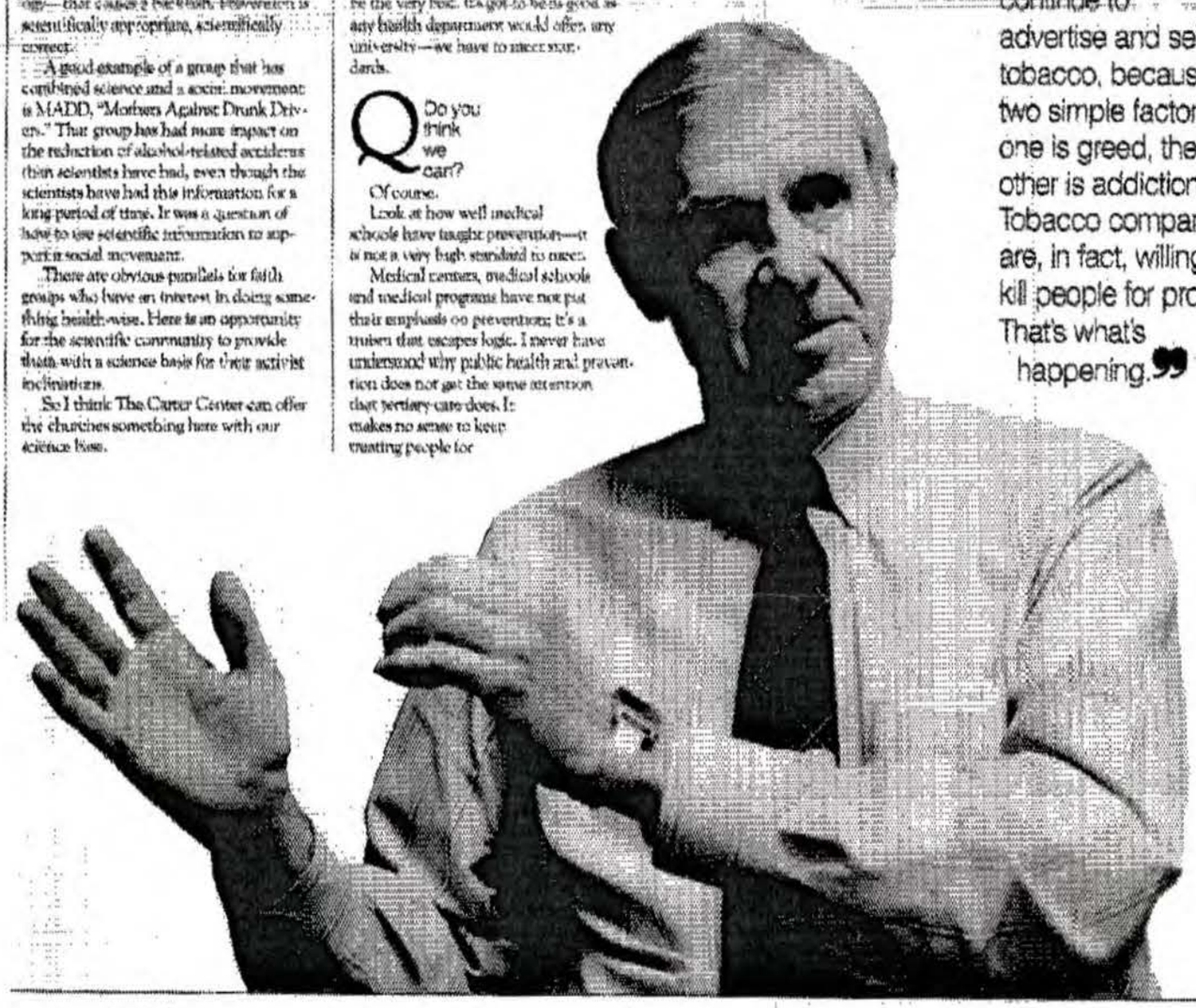
It is faith that links these mundane, sustained efforts and the profound impact they have, because you can't see results outside faith. It is not evident. The Bible—and I use it as an example because I'm most familiar with it—speaks often of "planting seeds." In a sense, that's what faith groups can do in their own health initiatives. If they plant the seeds of prevention, the public will reap a harvest of good health.







"Tobacco is the leading cause of death in the United States. Yet we continue to advertise and sell tobacco, because of two simple factors: one is greed, the other is addiction. Tobacco companies are, in fact, willing to kill people for profit. That's what's happening."



SENT BY:KINKO'S ; 3-31-94 ; 18:57 ; KINKO'S I ATLANTA ; #2





Health services sponsored by the Baltimore faith community are diverse. At New Song church volunteer Dr. Mary Schipper examines Tyrone Henderson, 10 (far left). At Harvey Johnson Homes, a high-rise for the elderly, volunteer Shirlene Myers serves lunch to 83-year-old resident Ida Johnson (left).

"What we should be about," says Banner, "is using the mission of the church as an effective way to deliver health care to underserved communities."

MOST POOR PEOPLE neglect their health. Other survival issues seem more pressing. Because of schedules or circumstances or the stigma of "public" institutions, many reject city health care services. Others don't want to admit they can't care for themselves. Many feel demeaned by the red tape they face to receive free treatment.

"There is none of this negative aura connected with faith-based health centers," says Ray. "At a church, nobody is rejected. It's a place where they are cared for and loved. And the whole person can be healed."

This belief led a group of 55 East Baltimore pastors to form CURE—Clergy United for Renewal in East Baltimore. With funding from Johns Hopkins School of Medicine and the Kellogg Foundation, CURE now sponsors three health centers called Heart, Body and Soul, where patients are screened for illnesses ranging from hypertension to AIDS. CURE also sponsors a health fair that offers free health screening in a neighborhood church each Sunday afternoon. Like other faith-based centers, CURE relies heavily on volunteers.

The Rev. Doug Wilson is community services coordinator for Johns Hopkins Oncology Center and liaison between Hopkins and CURE. "In the African-American community there is an emergency room syndrome," he says. "CURE is trying to educate people toward prevention. These centers make that possible."

IN TERMS OF BODIES HEALED, lives salvaged and dollars saved, Ray believes there is no way to estimate the contributions of Baltimore's faith-based health care. But with volunteers reaching across racial, economic and institutional lines, there is strong evidence that communities are being healed.

"The only way a community can heal itself," says Ray, "is if it takes charge and replicates what New Song, CURE and other faith-based centers are doing."

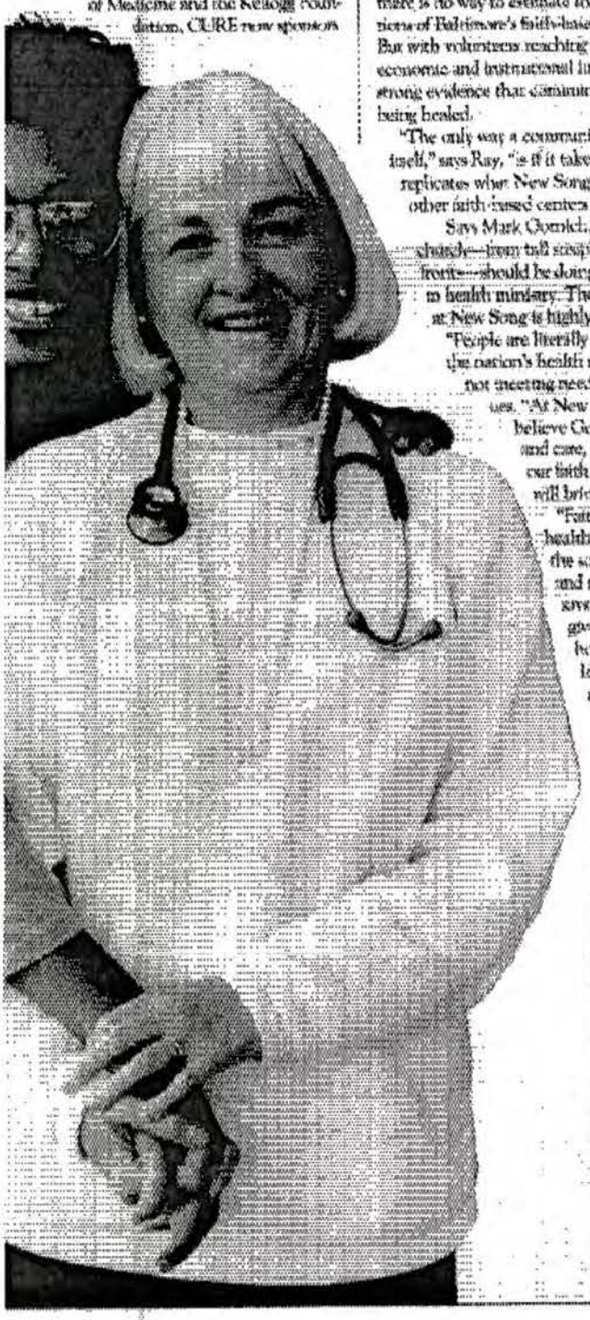
Says Mark Gornick, "Every church—from tall steeples to storefronts—should be doing something in health ministry. The care we give at New Song is highly replicable.

"People are literally dying because the nation's health care system is not meeting needs," he continues. "At New Song we believe God's concern and care, as lived out by our faith community, will bring change."

"Faith-based health centers treat the soul, the spirit and the body," says Ray. "They give hope. And hope changes lives and communities."

"At a church, nobody is rejected. It's a place where they are cared for and loved. And the whole person can be healed."
—Selwin Ray

"People are literally dying because the nation's health care system is not meeting needs."
—Mark Gornick



Community advocate Loreta Smith passes out literature describing health services in Sandtown.



Beyond Pills & Pain

One of the nine community meetings held by the Interfaith Health Program in 1993 was in Baltimore. The city struggles against the familiar litany of drugs, violence, joblessness and too many people left out of too much. But unlike many cities, Baltimore has experienced important successes in redeveloping its inner core near the harbor, in a large-scale citizen movement and through creative projects in the field of housing and health. Many community leaders we met were hesitant to celebrate their successes for fear of lessening the urgency about the remaining tasks. However, it is clear that Baltimore has much to teach.

1. *Think prevention.* Baltimore is known for its world-class medical research and teaching facilities. It is becoming known for community prevention initiatives such as the Heart, Body, Soul partnership in which Johns Hopkins Hospital and 200 congregations in East Baltimore link to fight urban illnesses and the city health department's youth health clinic at Mondawmin Mall. Baltimore shows the struggle for preventive programs are worth it. In the Sandtown neighborhoods, for instance, the infant mortality rate and number of low-birth-weight babies have been significantly reduced.

2. *Connect with other issues.* Health projects have gained from links to the highly visible success in housing. The Nehemiah Project, which has resulted in 227 new homes in Sandtown, also resulted in a new prenatal clinic. New Song Church, the home base for Habitat for Humanity, is also home to a free clinic. Health is more than a "special interest"—it is one of the key priorities in building the community.

3. *Earn the right to speak.* When you raise your hand to speak in Baltimore, you're expected to have dirt under the fingernails. Muslims, Jews, Catholics, Presbyterians and Seventh Day Adventists could be aggressive with public agencies because they had shown their seriousness and competence in the streets.

4. *Pull together.* Baltimore is finding ways to get organizations to work together. Both the mayor and health commissioner have assigned staff to relate to religious groups. Dr. Levine of Johns Hopkins has spent hundreds of hours with pastors, listening and discussing how to work in their neighborhoods.

There is much yet undone: few health workers in East Baltimore know their colleagues in West Baltimore. Collaboration is time-consuming hard work. But Baltimore shows it pays off. —Gary Gunderson

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Health Reform And Mental Illness

Perspective from John Gates, Ph.D.

DIRECTOR, MENTAL HEALTH PROGRAM, THE CARTER CENTER

Though mental health is virtually undisputed as an integral part of good health, it is rarely insured as adequately as physical illness. But according to John Gates, director of the Mental Health Program of the Carter Center, mental health is part of the discussion in the Clinton health care reform plan—and that fact, he says, is largely due to the efforts of former First Lady Rosalynn Carter and Tipper Gore, wife of Vice President Al Gore.

"Rosalynn Carter has been trying for more than 20 years to get people to overcome stigma against people with mental illness," says Gates. "People refuse to look at the facts—that's part of the reason mental health benefits are not on a par with physical health benefits."

The two women are largely responsible for getting two fundamental principles into the reform package.

✔ The first principle, says Gates, is parity: the inclusion of benefits for mental illness on a par with benefits for physical illness. Gates explains, "Historically, most policies have limitations on mental health that are significantly below caps on physical health—a common policy might have a $1 million ceiling on physical conditions, for example, but only $50,000 for mental health problems."

✔ Second is arbitrary limitations setting predetermined limits on the number of insured outpatient therapy visits. "The analogy in physical illness," says Gates, "would be to set a limit on radiation treatments for cancer." Arbitrary limits on outpatient therapy, no matter what the illness, are in the Clinton plan, but are intended to be phased out by 2001.

In spite of this, he says, the plan offers "significant progress."

"If you're looking at the whole range of health care, it's impossible to do everything at once."

The best news in the Clinton plan, says Gates, is that it proposes universal access. "This is especially good for people with mental illness," he says, "because people with mental illness tend to have a higher rate of physical problems than the rest of the population."

The President's plan eliminates lifetime limitations and provides for mental health screenings as part of preventive care. This is especially beneficial for children. The plan also provides unlimited emergency services.

The plan covers alternatives to hospitalization, such as some residential treatment programs and some home-based care. "In the case of an autistic child, for example, there are specially trained behavioral aides who can come in and help before the parents burn out and have to institutionalize the child," he explains. "You can get 120 days of service if it will prevent hospitalization."

Medications for mental illness will be treated on a par with medications for physical illness.

The fourth and most hotly debated area of the plan is outpatient psychotherapy.

"There is a pervasive skepticism," he says, "that generous benefits will break the bank. People think this for several reasons: they think 'mental health' is too vague and varied a category, they think taxpayers will end up paying for any minor disturbance someone had during the day . . . a fight with a boyfriend, you're frustrated with your children. Also," he continues, "many people still think that mental illness is simply weakness of character or the result of bad parenting and that they shouldn't have to pay for it."

Fear of skyrocketing costs is unfounded, he says. "The data from studies of generous plans indicate that mental health costs tend to run out at 13-14 percent of total health care costs. The fact is that people do not go rushing to the shrink's couch. The average number of visits—in generous packages—turns out to be 12."

Gates sees another hindrance to progress in mental health care is a pervasive prejudice that mental illness is not really treatable. Again, he says, the statistics disagree. "The efficacy rate of treatment for manic depression is 80 percent. For acute schizophrenia, it's 70 percent. In contrast, the efficacy rate for angioplasty (ballooning arteries to reduce blockage) is 41 percent. But no one argues whether a health care plan ought to cover angioplasty."

Gates believes the cost of not treating mental illness is "staggering. By treating mental illness we can probably reduce a lot of expense in generic health care.

"It is estimated that about 50 percent of office visits that Americans make to their family physician are really visits prompted by psychological factors," he explains. "Half the visits don't result in a diagnosis of any physical problem."

What that means to Gates is that health is extremely dependent upon "what goes on between the ears. Seven out of the 10 leading causes of death in this country have to do with our behavior," he says. "That says something about the need to start paying much more attention to mental/emotional problems than we have historically. Increasingly, both our hard science traditions and our spiritual wisdom are saying the same kinds of things."

Common Limitations In Insurance Coverage for Mental Illness

	PHYSICAL ILLNESS	MENTAL ILLNESS
OUT PATIENT VISITS	20% COPAYMENT	50% COPAYMENT
MAXIMUM INPATIENT DAYS	365 DAYS	30-60 DAYS
MAXIMUM LIFETIME CAPS	$1,000,000	$20,000 TO $50,000

Health is extremely dependent upon "what goes on between the ears. Seven of the 10 leading causes of death in this country have to do with our behavior."

RESOURCES AND TOOLS

The Best Medicine

By MIMI KISER, RN, MPH

PROGRAM FUNDING SOURCE: Robert Wood Johnson Foundation is providing start-up grants of $25,000 to congregations to develop interfaith caregiving ministries. The Interfaith Volunteer Caregivers Program is a model for this initiative which involves community coalitions serving the needs of people of all ages with chronic health conditions.

✔ **Inquiries:** Kenneth G. Johnson, MD, director
Faith in Action Health Services Research Center,
368 Broadway, Suite 103, Kingston, NY 12401
(914) 331-0016 • Fax (914) 331-4191

AIDS UPDATE: Few Americans do not know someone infected with the HIV virus. Two publications are helpful in understanding the growing epidemic.

■ *AIDS and the African-American Church: An AIDS Education and Training Guide for African-American Religious Leaders.*

This user-friendly 6-module format, designed for objective-oriented, self-instruction, covers a range of information, including AIDS transmission, signs and symptoms, effective communication, the rights of people with AIDS, and conducting AIDS activities in the community. The guide effectively shows how the church community can be part of the solution to this public-health threat. Activities in this guide work best with the participation of a health educator.

✔ **National Alumni AIDS Prevention Project**
Veronica Hartwell, Coordinator
Jackson State University
P.O. Box 18890
Jackson, MS 39217 • (601) 968-2519

■ *The Church's Response To The Challenge of AIDS/HIV: A Guideline for Education and Policy Development.*

Designed for religious leaders, this publication provides an in-depth framework for a congregational approach to AIDS/HIV. A "problems and concerns" format serves as a sequential decision-making guide. It covers such topics as evaluation of ministry needs and priorities, key decisions in developing policies and plans for education and developing attitudes and programs aimed at preventing risk behaviors. Noteworthy is an extensive appendix of resources for church and health related information and services.

✔ **Americans for a Sound AIDS/HIV Policy**
P.O. Box 17433
Washington, D.C. 20041 • (703) 471-7350

✔ **MAP International**
P.O. Box 215000
Brunswick, GA 31521 • (912) 265-6010

❑ The **National AIDS Clearinghouse** is making an effort to reach out to the religious community with resources. Most valuable are references and descriptions of educational materials (manuals, teaching guides, fact sheets) developed by and for religious organizations. Call (800) 458-5231.

❑ The **Office of Disease Prevention and Health Promotion's National Health Information Center** has publications helpful for planning and implementing health programs/ideas include "National Health Observances," "Health Risk Appraisals," and "Locating Resources for Healthy People 2000 Health Promotion Projects." Call (301) 251-1222.

❑ The **Health Ministries Association** (HMA) is a national nonprofit membership organization that encourages, supports, and develops whole person ministries in congregations and in the communities they serve. One of the many benefits and resources provided by HMA is a comprehensive manual on "Beginning A Health Ministry." Contact the HMA for information: Health Ministries Association, 2427 Country Lane, Poland, OH 44514, (800) 852-5613

❑ **Congregation For A Healthy St. Louis** has developed "A Workbook for Congregational Ministries in Health and Wholeness" called *Reclaiming Our Legacy*. This manual can help guide a congregation to its fullest healing potential. One distinguishing asset is the homework and collaboration that went into a unit describing the healing legacies from different faith traditions.

Available from: Linda Kessler, Program Director, Interfaith Partnership of Metropolitan St. Louis, 418 S. Adams Ave. St. Louis, MO 63122 • (314) 821-3808

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SENT BY:KINKO'S ; 3-31-94 ; 19:05 ; KINKO'S I ATLANTA→ ;# 5

INTERFAITH HEALTH

Natural Allies

By TOM DROEGE, PhD
Associate Director, Interfaith Health Program

Pairing faith and health in the same title, as in Interfaith Health, implies a link between the two that is not obvious to everyone. Ask people at random what comes to their mind when you mention the word "health." Few, even those of deep faith, will say, "pastor" or "synagogue." Ask what connection they see between faith and health, and they'll refer more often to faith healers than to their own places of worship.


Tom Droege

How can we help such people see the link between their health and their faith? I think the key term is "spiritual." Think of spirituality as meaning "maintaining hope and self-esteem, forming core values, and serving others." There is a strong link between spirituality so defined and health. Those who are spiritually strong live longer and healthier lives. Promoting spirituality is promoting health.

The primary purpose of faith groups is to nurture spiritual formation. While recognizing spirituality as a dimension of health that is common to all humanity, faith groups pay particular attention to a transcendent source of meaning, value and hope.

Worship places are health places by virtue of the wellness they promote. Every faith tradition gives its adherents hope, a sense of meaning and purpose, a core set of values that shape personal and communal identities, a commitment to social justice and equity and a desire to serve others. That is health promotion through spiritual growth, and it has implications for physical, emotional and social health as well.

Faith groups are also international health networks. A 1993 survey of 137,000 Protestant congregations showed that more than three-quarters of responding churches are addressing at least one health concern, while half are addressing three or more. Faith communities are natural allies of health agencies in disease prevention and health promotion.

Now faith groups are beginning to shift from healing to health ministries, from a focus on sick people to an emphasis on healthy people. As this develops, what better partners for accomplishing the goal of health promotion can they find, than health agencies that have disease prevention as their major purpose?

Every faith tradition encourages its communities to reach out to others in need, to heal the brokenness of the world, to extend "health" to others, even if that means risking one's own health, as medical missionaries did in bringing health care to developing countries.

Spirituality's improved health of self and community → service to others → improved health of those served. This is a gracious rather than vicious cycle. It is a mission that all faith communities can claim. It can be a basis for interfaith cooperation in building coalitions for health promotion and caregiving.

Making the connection between faith and health holds great promise for the improvement of health. It is the mission of Interfaith Health to heighten awareness of this vital link and mobilize people of faith everywhere to act on the promise it holds.

An Ounce of Prevention

An Interview with William H. Foege, M.D.

FELLOW FOR HEALTH, THE CARTER CENTER

Dr. Foege is an epidemiologist who is widely recognized as a key member of the successful campaign to eradicate smallpox in the 1970s. After serving as a medical missionary in Nigeria, Dr. Foege became chief of the CDC Smallpox Eradication Program and was appointed director of the U.S. Centers for Disease Control in 1977. In 1986, he joined The Carter Center as executive director, a post he relinquished in 1993 to become executive director of the Interfaith Health Program.

A real scientific revolution has occurred over the past few decades, and while it has an impact on intensive care units, the real impact occurs long before you get to a hospital, even before you get to a clinic or a doctor's office. The real impact is that you can now determine your health future.

Q If individuals have power over their own health conditions, why are Americans spending so much on medical care?

Because there is such a wide gap between what is actually happening and what could be happening.

It comes down to a few, narrow risk factors. Tobacco is number one; diet is number two; alcohol number three.

All are within the control of people.

Q Tobacco is the number one health risk in the United States today?

Yes, the leading cause of death is tobacco, with 400,000 deaths a year. Diet is the second leading cause, because of how it affects heart disease and cancer; we attribute about 300,000 deaths to diet. Alcohol contributes to about 100,000 deaths.

Q You say tobacco and alcohol are major causes of death, yet those words never appear on death certificates. Explain that.

With death certificates, we put down what organ failed. We don't go back and ask what caused that organ to fail. So instead of putting down tobacco, we put down lung cancer, or we put down coronary artery disease, or we put down pancreatic cancer, things that tobacco does.

If you ask what caused that organ to fail, tobacco is the single most important factor; it is such an important cause of death in this country that today we will have about 5,400 funerals; more than 1,000 of those will be due to cigarettes alone.

Similar statistics are available for diet, alcohol and violence. So if we accept that the leading causes of death are within the control of individuals—and I think most people have failed to appreciate this—then faith groups have a great contribution to make, because they can offer something special in *preventive* medicine.

Q Let's focus on the enigma of tobacco for a moment. It's the leading killer. Yet I know a woman, very intelligent, who smokes, she says, "Don't tell me about it because I know all the things there are to know," and she keeps right on puffing. How do we convince people, for their own health, to stop smoking?

It's like gun control. We know how to save lives, but we don't have the cooperation of enough people to make that happen. We shouldn't have any advertising of tobacco products, that is ridiculous, and the government shouldn't promote tobacco.

These things reflect two factors: one is greed, the other is addiction.

Tobacco companies are, in fact, willing to kill people for profit. It's that simple.

I know of at least one tobacco executive who changed jobs because he said he did not want his children knowing what he was doing. This is the kind of message we should try to get to the public. We treat tobacco executives as if they are legitimate people, that selling tobacco is a correct thing to do, and we welcome them to our receptions, dinners, fund raisers. It's time to say that this is not an acceptable way to make a living, and that there is a difference between legal and moral—it may be legal but it is hard to justify it as being moral.

Q That still leaves the tobacco addicts.

Yes, addiction is so powerful, so absolutely powerful, yet when

The 10 Leading Medical Causes of Death . . .

Heart Disease	720,000
Cancer	505,000
Cerebrovascular Disease	144,000
Accidents	92,000
Chronic Pulmonary Disease	87,000
Pneumonia and Influenza	80,000
Diabetes	48,000
Suicide	31,000
Liver Disease, Cirrhosis	26,000
AIDS	25,000
TOTAL	2,148,000

. . . And Lifestyle Factors Leading to Half of Them

Tobacco	400,000
Diet, Sedentary Lifestyle	300,000
Alcohol	100,000
Infections	90,000
Toxic Agents	60,000
Firearms	35,000
Sexual Behavior	30,000
Motor Vehicles	25,000
Illicit Drug Use	20,000
TOTAL	1,080,000

The nation's investment in prevention is estimated at less than 5 percent of the total annual health care cost.



Stations of Healing and Hope

BY KAYTIE GILL
Photographs by Dan Chasnoff

Faith-based health centers are offering Baltimore's core communities healing and hope.

Computer expert Fred Bailey had been unemployed for more than a year. One day, while perusing his Baltimore neighborhood bulletin board for job listings, his attention was drawn to a small brochure. He read it hurriedly. Then again.

"The Shepherd's Clinic," Bailey read for the third time, "provides medical services only for people who are not covered by medical insurance."

"I must have stood there for 15 minutes," says Bailey. "It sounded too good to be true. Finally, I realized I had absolutely nothing to lose."

Bailey suffered from acute, chronic back pain. With no medical insurance, he could not afford a doctor. Without treatment, he could not work.

"My first visit to Shepherd's Clinic was like a miracle," Bailey recalls. Physician volunteer William Finney, an internationally renowned neurosurgeon, diagnosed a herniated disc and recommended surgery. A former chief of staff at Baltimore's Union Memorial Hospital, Finney managed to get Bailey's hospital stay without cost and convinced his former partner to operate without a fee.

Now free of pain, Bailey is working again. "This is the greatest thing that ever happened to me," he says. "If Dr. Finney ran for president, I'd vote for him."

Shepherd's Clinic, housed in a building owned by Seventh Baptist Church, is an ecumenical ministry staffed — except for a part-time administrator — by volunteers. "What we do here," says Finney, "is only a drop in the bucket. But it's so needed."

Finney is painfully aware that the Fred Baileys of this nation are legion. For 37 million people in the United States, health care — except for emergency treatment — is not available. In effect, getting sick is a luxury they cannot afford.

But there are signs of hope. The Shepherd's Clinic is only one of many faith-based health centers in Baltimore and around the nation that fill in the gaps of medical service available to the poor and uninsured. Staffed with volunteers who are motivated by their faith and financed largely by private funds, they provide communities with a dose of health and hope.

Says Selwin Ray, policy adviser to Baltimore City's health commissioner, "Faith-based healthcare centers, by ministering to the whole person, fill a void that the city can't possibly fill."

Pastor Mark Gornich agrees. At New Song Community Church in Sandtown, he lives and works in an area devastated by poverty, drugs, crime and disintegrating families. With a median income of only $8,500, families in Sandtown struggle daily just to survive.

But at New Song church, community-based programs in education, employment, housing and health give support to residents' efforts for more productive lives.

Gornich tells of one woman whose drug addiction made her unable to care for herself or her family. When she was refused treatment in a state facility, a family at New Song Church took her in.

"They took her home and detoxed her," says Gornich. "Can you imagine what a struggle that was? But with the support of the church community, she was healed. Then we helped her find a job, so she could support her family.

"Don't get me wrong. Everything is not rosy. But her whole life has turned around."

IT'S STORIES LIKE THESE that keep volunteers going. Baltimore's Dr. Mac Boomer is medical director of Maryland's prison health services; his wife, Nina, is a pediatrician. For three years, both volunteered many hours to meet health needs of the low-income community around the Seventh Day Adventist church where they are members.

From office to AIDS prevention, Baltimore faith groups reach out to their communities. At Seventh Baptist Church (above), a volunteer welcomes a client to the clinic. Below: AIDS prevention and birth control are discussed with teenagers at the Young People's Health Connection. Monica Williams and nurse practitioner Judy Gebhardt have become close friends at the Connection. Seventeen-year-old Marlon (left in photo) has a 17-month-old baby who receives health screening.



A PATTERN FOR CHANGE

Better Service

For most low-income people, the barriers to health care are substantial. Public and private health-care agencies are seldom located in the same building—often not even in the same area, making it difficult to get to, enroll in, and benefit from, assistance programs.

Low-income people often face transportation problems. Hours for public and private service agencies—weekdays 8-5—present handicaps. There are also long waiting lines, difficult forms and language barriers.

Despite strong efforts made by caring agency staff, many needy families fall through the cracks, especially those with children.

Income of Families at Fair



In Tucson, service agencies decided to eliminate obstacles in providing a wide range of services in a single-setting event. Since 1989, more than 30 nonprofit, for-profit and government agencies have turned a centrally located high school gymnasium into a weekend "one-stop shopping center" for health and human services.

Designed to aid a traditionally under-served population, the Children's Assistance and Resource Event—the C.A.R.E. Fair—offers a way for low-income families to reach the assistance they need in food, day-care, transportation, utilities, housing, employment and medical/dental/health services.

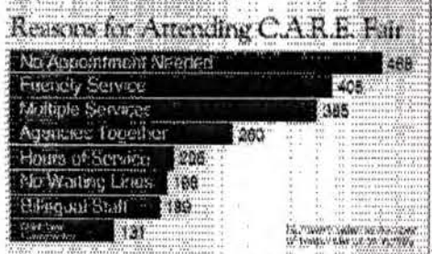
The C.A.R.E. Fair makes things easy. It begins with a "Passport" intake form. Each family fills out one form that includes information—family demographics from birth dates to Social Security numbers—that are used by all agencies. The Passport is then copied by each agency, eliminating repetitious form-filling-out.

Long lines and excessive waiting are reduced by allowing participants to obtain assistance from one agency while awaiting services from another. In fact, a family typically spends only 1½ hours at the Fair—during which an average of five services are accessed.

Services requiring the same information—WIC, Head Start and schools, for example—share information about physical assessments.

As evidence of the Fair's success over the past five years it has served more than 18,000 people. More attend each year—more than 1,200 families, nearly 5,000 people in 1991. And the agencies involved continue to express satisfaction at the mission accomplished in this dramatic, "one-stop health-shop" event.

Reasons for Attending C.A.R.E. Fair



For more information, call or write Silver Center, Attn: C.A.R.E. Fair, P.O. Box 14821, Tucson, AZ 85732. Phone: (602) 298-5365.



In Evanston, Ill., The Free Synagogue's healing services draws 5-10 people once a month.

The Spiritual Dimension

"The healing service is for anybody who has a need for healing. It is based on the notion that in Judaism we ask for healing of body and healing of spirit."

By AMY GREENE
Staff Reporter
Photographs by Jim Wright

When the Rabbi Peter Knobel and his north-Chicago suburban congregation decided to start a monthly healing service about a year ago, they didn't really know what to expect. Now he believes it is "among the most important things a congregation can do, because it brings the whole question of health and healing back into the spiritual dimension."

Knobel's congregation, The Free Synagogue in Evanston, Ill., is made up of 780 upper middle-class households. Knobel describes the Reform synagogue as both "very traditional and very experimental."

Rabbi at the synagogue for the past 14 years, Knobel says the monthly Thursday night services grew directly out of a healing project they worked on in conjunction with the Parkridge Center for Health, Ethics and Faith. They began with a focus on those with chronic illness, he says, but have expanded the concept of healing to include those in any kind of pain or ill health—physical or otherwise.

For the actual service, Knobel credits the work of two other rabbis, Yosi Kahn on the West Coast and Deborah Zecker on the East, they created a liturgy for healing services. The congregation's own cantor, Jeffrey Klepper, has written original music for the services.

Knobel says the service is "almost leaderless" with its concentration on silence and meditation. He says light is an important element in the services, which usually begin with the lighting of a candle. "I usually do a directed meditation on the theme of light," says Knobel.

"The service is for anybody who has a need for healing," says Knobel, "whether someone with an illness, or someone thinking about someone who is ill, or someone who has some kind of spiritual pain. It's not aimed necessarily at physical pain. It is really based on the notion that in Judaism we ask for healing of body and healing of spirit."

The services draw from "five to 50" people each week, mainly from the congregation. But the temple plans a move "to make the community more aware of the services, now that we're feeling more comfortable with what we're doing."

Knobel hopes the service will grow. "My sense is that it is going to be ongoing, and that when it really takes off, it will do so in a big way, because I think there is a big need out there."

Knobel says healing services are becoming quite common. The Jewish community, under the auspices of the National Jewish Healing Center, plans a retreat to train rabbis in the healing process.

The rabbi cites the strong tradition of healing within Judaism as a main resource. "First, there is prayer; second, care-giving and third, medical attention. The three are always brought together. Plus a strong tradition of preventive medicine. It's a very comprehensive thing."

The preventive tradition, he says, means "you're supposed to treat your body as a vehicle which is a gift from God and therefore is to be nurtured and treasured. You're supposed to eat properly, avoid things that harm the body, and seek medical attention when needed."

The more we learn about harmful behaviors such as using tobacco and consuming too much fatty food, says Knobel, "the more we are saying that it's part of a person's religious responsibility to avoid those things that cause long-term, not just short-term, harm."

Does health then become a spiritual issue?

The rabbi gives an emphatic, "Yes."

Rabbi Peter Knobel lights a candle to begin the service's meditation time. Cantor/guitarist Jeffrey Klepper accents with the music.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Food and Drug Administration
Rockville MD 20857

MEMORANDUM

Date: APR 4 1994

From: Associate Commissioner for AIDS and Special Health Issues

Subject: Public Hearing on Acyclovir as an OTC Treatment - INFORMATION

To: Kristine M. Gebbie, RN, MN, FAAN
National AIDS Policy Coordinator

The Food and Drug Administration (FDA) will hold a public hearing, on Thursday, May 19, 1994, to discuss acyclovir as an over-the-counter (OTC) treatment for recurrent genital herpes. If the supplemental New Drug Application is approved, acyclovir would be the first systemically administered antimicrobial agent available without prescription in the United States, and the first OTC product for the treatment of a sexually transmitted disease.

The purpose of this hearing is to seek public opinion from both health care professionals and consumers on the advantages and disadvantages of switching acyclovir from prescription to OTC status. FDA is contacting community organizations and professional societies to invite them to make an oral presentation at the hearing or submit a written statement to the public record summarizing their viewpoints. FDA will use the public comments in the evaluation of the supplemental New Drug Application.

Attached a copy of the March 7, 1994 Federal Register notice which discusses the hearing. If you would like additional information regarding the hearing, please call me at (301) 443-0104.

Randolph F. Wykoff, MD, MPH & TM

Attachment

RECEIVED
APR - 6 1994

Food and Drug Administration

Advisory Committee; Notice of Meeting

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: This notice announces a forthcoming meeting of a public advisory committee of the Food and Drug Administration (FDA). This notice also summarizes the procedures for the meeting and methods by which interested persons may participate in open public hearings before FDA's advisory committees.

MEETING: The following advisory committee meeting is announced:

Joint Meeting of the Antiviral Drugs and Nonprescription Drugs Advisory Committees

Date, time, and place. May 19, 1994, 3:30 p.m., conference rms. D and E, Parklawn Bldg., 5600 Fishers Lane, Rockville, MD.

Type of meeting and contact person. Open public hearing, 3:30 p.m. to 4:30 p.m., unless public participation does not last that long; open committee discussion, 4:30 p.m. to 6 p.m.; Lee L. Zwanziger, Mae Brooks, or Valerie Mealy, Center for Drug Evaluation and Research (HFD–9), Food and Drug

Administration, 5600 Fishers Lane, Rockville, MD 20857, 301–443–4695.

General function of the committees. The Antiviral Drugs Advisory Committee reviews and evaluates available data concerning the safety and effectiveness of marketed and investigational human drug products for use in the treatment of acquired immune deficiency syndrome (AIDS), AIDS-related complex (ARC), and other viral, fungal, and mycobacterial infections. The Nonprescription Drugs Advisory Committee reviews and evaluates available data concerning the safety and effectiveness of over-the-counter (nonprescription) human drug products for use in the treatment of a broad spectrum of human symptoms and diseases.

Agenda—Open public hearing. Interested persons may present data, information, or views, orally or in writing, on issues pending before the committees. Those desiring to make formal presentations should notify the contact person before May 9, 1994, and submit a brief statement of the general nature of the evidence or arguments they wish to present, the names and addresses of proposed participants, and an indication of the approximate time required to make their comments. Those persons or groups presenting views on this topic at the public hearing before the Commissioner of Food and Drugs, earlier the same day, need not make a second presentation because views presented in the earlier meeting will be taken into consideration in this joint advisory committee meeting.

Open committee discussion. The committees will discuss jointly the issues and concerns relating to over-the-counter availability of acyclovir for the treatment of recurrent genital herpes, taking into consideration the views expressed at the public hearing scheduled earlier the same day. (See a notice of public hearing on the proposed switch of acyclovir from prescription to over-the counter status published elsewhere in this issue of the Federal Register.)

FDA public advisory committee meetings may have as many as four separable portions: (1) An open public hearing, (2) an open committee discussion, (3) a closed presentation of data, and (4) a closed committee deliberation. Every advisory committee meeting shall have an open public hearing portion. Whether or not it also includes any of the other three portions will depend upon the specific meeting involved. There are no closed portions for the meetings announced in this notice. The dates and times reserved for the open portions of each committee meeting are listed above.

The open public hearing portion of each meeting shall be at least 1 hour long unless public participation does not last that long. It is emphasized, however, that the 1 hour time limit for an open public hearing represents a minimum rather than a maximum time for public participation, and an open public hearing may last for whatever longer period the committee chairperson determines will facilitate the committee's work.

Public hearings are subject to FDA's guideline (subpart C of 21 CFR part 10) concerning the policy and procedures for electronic media coverage of FDA's public administrative proceedings, including hearings before public advisory committees under 21 CFR part 14. Under 21 CFR 10.205, representatives of the electronic media may be permitted, subject to certain limitations, to videotape, film, or otherwise record FDA's public administrative proceedings, including presentations by participants.

Meetings of advisory committees shall be conducted, insofar as is practical, in accordance with the agenda published in this Federal Register notice. Changes in the agenda will be announced at the beginning of the open portion of a meeting.

Any interested person who wishes to be assured of the right to make an oral presentation at the open public hearing portion of a meeting shall inform the contact person listed above, either orally or in writing, prior to the meeting. Any person attending the hearing who does not in advance of the meeting request an opportunity to speak will be allowed to make an oral presentation at the hearing's conclusion, if time permits, at the chairperson's discretion.

The agenda, the questions to be addressed by the committee, and a current list of committee members will be available at the meeting location on the day of the meeting.

Transcripts of the open portion of the meeting may be requested in writing from the Freedom of Information Office (HFI–35), Food and Drug Administration, rm. 12A–16, 5600 Fishers Lane, Rockville, MD 20857, approximately 15 working days after the meeting, at a cost of 10 cents per page. The transcript may be viewed at the Dockets Management Branch (HFA–305), Food and Drug Administration, rm. 1–23, 12420 Parklawn Dr., Rockville, MD 20857, approximately 15 working days after the meeting, between the hours of 9 a.m. and 4 p.m., Monday through Friday. Summary minutes of the open portion of the meeting may be requested in writing from the Freedom of Information Office (address above) beginning approximately 90 days after the meeting.

This notice is issued under section 10(a)(1) and (2) of the Federal Advisory Committee Act (5 U.S.C. app. 2), and FDA's regulations (21 CFR part 14) on advisory committees.

Dated: March 1, 1994.

Jane E. Henney,

Deputy Commissioner for Operations.

[FR Doc. 94–5129 Filed 3–2–94; 2:55 pm]

BILLING CODE 4160–01–F

[Docket No. 94N–0006]

Proposed Switch of Acyclovir from Prescription to Over-the-Counter Status; Public Hearing

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice of public hearing; request for comments.

SUMMARY: The Food and Drug Administration (FDA) is announcing a public hearing regarding the proposed over-the-counter (OTC) availability of orally administered acyclovir. The purpose of the hearing is to solicit information from, and the views of, interested persons, including scientists, professional groups, and consumers, on the issues and concerns relating to the proposed OTC availability of acyclovir for the acute and suppressive management of recurrent genital herpes.

DATES: The public hearing will be held on Thursday, May 19, 1994, from 8 a.m. to 3 p.m. Submit written notices of participation and comments by April 29, 1994. Written comments will be accepted until June 20, 1994.

ADDRESSES: The public hearing will be held at the Parklawn Bldg., conference rms. D and E, 5600 Fishers Lane, Rockville, MD 20857. Submit written notices of participation and comments to the Dockets Management Branch (HFA–305), Food and Drug Administration, rm. 1–23, 12420 Parklawn Dr., Rockville, MD 20857. Two copies of any comments are to be submitted, except that individuals may submit one copy. Comments are to be identified with docket number 94N–0006. Transcripts of the hearing will be available for review at the Dockets Management Branch (address above).

FOR FURTHER INFORMATION CONTACT: Lee L. Zwanziger, Center for Drug Evaluation and Research (HFD–9), Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20857, 301–443–4695.

I. Background

SUPPLEMENTARY INFORMATION: Acyclovir is a synthetic purine nucleoside analogue with in vitro inhibitory activity against herpes simplex viruses 1 and 2 and varicella zoster virus. An oral formulation of acyclovir was approved in 1985 with initial indications for the treatment of first episode and recurrent genital herpes. Since 1985, FDA has also approved the oral formulation of acyclovir for the treatment of herpes zoster and chickenpox, and for the suppression of recurrent genital herpes.

Burroughs-Wellcome has discussed publicly its intention to seek approval for a supplemental new drug application (NDA) to switch acyclovir from prescription to OTC status (e.g., at the July 1993 International Herpesvirus Workshop). Burroughs-Wellcome has also discussed publicly that this application is currently under review at FDA (e.g., at the October 1993 Interscience Conference on Antimicrobial Agents and Chemotherapy).

The proposed switch would apply only to 200-milligram capsules with proposed indications for the acute and suppressive management of recurrent genital herpes. If the supplemental NDA is approved, acyclovir would be the first systemically administered antimicrobial agent available without prescription in the United States, and it would also be the first OTC product for the treatment of a sexually transmitted disease.

II. Scope of the Hearing

In light of the many complex scientific and public health issues raised by this application, FDA is soliciting broad public participation and comment on the potential merits and disadvantages of this proposed switch. The agency encourages investigators with information relevant to this switch, as well as other interested persons, to respond to this notice. Examples of issues that are of interest to the agency include the following: (1) The implications of unrestricted availability of acyclovir for the transmission and asymptomatic shedding of herpes simplex virus; (2) the incidence and clinical significance of acyclovir-resistant herpes simplex virus; (3) the ability of patients to self-diagnose genital herpes (i.e., without consultation with a physician); (4) the potential for misuse for unapproved OTC indications (such as for chickenpox, shingles, and other viral illnesses); (5) the potential for adverse effects on the fetus; and (6) general issues of safety (and the incidence of adverse drug events) during widespread, unrestricted use. In addition, FDA is actively seeking the views of professional and consumer groups regarding the implications of this application for their constituent populations.

Elsewhere in this issue of the Federal Register, FDA is announcing a joint meeting of the Antiviral and the Nonprescription Drugs Advisory Committees under 21 CFR part 14. This meeting will allow FDA to receive comments from the advisory committee members as well as the general public. Those persons or groups presenting views at the public hearing before the Commissioner need not make a second presentation at the advisory committee meeting, because views presented in the earlier hearing will be taken into consideration in the joint advisory committee meeting.

III. Notice of Hearing Under 21 CFR Part 15

The Commissioner of Food and Drugs is announcing that the public hearing will be held in accordance with 21 CFR part 15. The presiding officer will be the Commissioner of Food and Drugs or his designee. The presiding officer will be accompanied by a panel of Public Health Service employees with the relevant expertise.

Persons who wish to participate in the part 15 hearing must file a written notice of participation with the Dockets Management Branch (address above) prior to April 29, 1994. To ensure timely handling, any outer envelope should be clearly marked with the docket number 94N–0006 and the statement "Acyclovir Hearing." Groups should submit two copies. The notice of participation should contain the person's name, address, telephone number, affiliation if any, brief summary of the presentation, and approximate amount of time requested for the presentation. The agency requests that interested persons and groups having similar interests consolidate their comments and present them through a single representative. FDA will allocate the time available for the hearing among the persons who file notices of participation as described above. If time permits, FDA may allow interested persons attending the hearing who did not submit a written notice of participation, in advance, to make an oral presentation at the conclusion of the hearing.

After reviewing the notices of participation and accompanying information, FDA will schedule each appearance and notify each participant by telephone of the time allotted to the person and the approximate time the person's oral presentation is scheduled to begin. The hearing schedule will be available at the hearing. After the hearing, it will be placed on file in the Dockets Management Branch under the docket number 94N–0006.

Under § 15.30 the hearing is informal, and the rules of evidence do not apply. No participant may interrupt the presentation of another participant. Only the presiding officer and panel members may question any person during or at the conclusion of their presentation.

Public hearings, including hearings under part 15, are subject to FDA's guideline (21 CFR part 10, Subpart C) concerning the policy and procedures for electronic media coverage of FDA's public administrative proceedings. Under § 10.205, representatives of the electronic media may be permitted, subject to certain limitations, to videotape, film, or otherwise record FDA's public administrative proceedings, including presentations by participants. The hearing will be transcribed as stipulated in § 15.30(b). Orders for copies of the transcript can be placed at the meeting or through the Dockets Management Branch (address above).

Any handicapped persons requiring special accommodations in order to attend the hearing should direct those needs to the contact person listed above.

To the extent that the conditions for the hearing, as described in this notice, conflict with any provisions set out in part 15, this notice acts as a waiver of those provisions as specified in § 15.30(h).

To permit time for all interested persons to submit data, information, or views on this subject, the administrative record of the hearing will remain open following the hearing until June 20, 1994. Persons who wish to provide additional materials for consideration should file these materials with the Dockets Management Branch (address above) by June 20, 1994.

Dated: March 1, 1994.

Michael R. Taylor,

Deputy Commissioner for Policy.

[FR Doc. 94–5130 Filed 3–2–94; 2:55 pm]

BILLING CODE 4160–01–F

Office of the Nuclear Waste Negotiator
3050 N. Lakeharbor Lane, Suite 100
Phone: (208) 334-9876 Boise, Idaho 83703 Fax: (208) 334-9880

RECEIVED
APR 12 1994

April 5, 1994

Ms. Kristine Gebbie
National AIDS Policy Coordinator
The White House
1600 Pennslyvania Avenue, N.W.
Washington, D.C. 20500

Dear Ms. Gebbie:

I wanted to thank you for representing the Secretary of Energy Advisory Board Task Force on Radioactive Waste Management in the recent presentation at my office. I was impressed with the number of panel members who attended and enjoyed meeting each one of you. I found your insights quite valuable.

I regret that I had to leave early, but my staff did brief me on what I missed. Maureen Conley and Bob Liimatainen join me in expressing appreciation for the work you did and for taking time out of your day to meet with us. I hope that we can implement some of the task force's recommendations as we move forward in our negotiated siting program.

Sincerely,

Richard H. Stallings
Negotiator

Office of the National AIDS Policy Coordinator

Executive Office of the President
750 17th Street, N.W. Suite 1060
Washington, D.C. 20500

Phone: (202)
Fax: (202)

Deliver To: Kristine Debbie

Jim Lew / Andrew fyi

Sent From:

____ Kristine Gebbie, RN, MN, National AIDS Policy Coordinator

____ Ann Page

Number of Pages: 4 + Cover Fax Number: 690-1096 Date: 4-12-94

Message:

I received this via my old office. He is asking for organizations to sign the letter which demands follow-up action from the PMT meeting and termination of Jim Curran as "Director / HIV/AIDS at CDC".

FAX TRANSMITTAL
8 APRIL 1994

TO: Frances Page
Francois-Xavier Bagnoud FAIM
1222 T Street, NW
Washington, DC 20009
Phone: 202-462-6740
Fax: 202-234-2705

FROM: Edward Zold
Phone: (415) 252.8956
Fax: (415) 252.9277

3 Pages to Follow

MESSAGE: Please review this document at your earliest convenience.
Although we would prefer organizational endorsements, individuals are welcome to sign on.
Please pass this on to any interested groups or individuals.
If you plan to sign on, please fax a signed note to that effect
as soon as possible.
Please call me at the above phone number with any questions.

Yours in the fight against AIDS,
Edward Zold
Task Force on State Managed AIDS Programs&
ACT UP/ Golden Gate

CONSENSUS DOCUMENT TO DR. JAMES CURRAN, CENTERS FOR DISEASE CONTROL AND PREVENTION
APRIL 25 1994

TO SIGN ON TO THIS DOCUMENT, PLEASE CONTACT EDWARD ZOLD BY PHONE (415-252-8956) OR FAX (415-252-9277) NO LATER THAN APRIL 24, 1994

Dr. James Curran
Director Office of HIV/AIDS

Dr. Curran:

We are extremely concerned and disconcerted by your failure to respond to the concerns expressed and demands made by the young adult working group at the March 3-4 P meeting in Washington D.C. on the CDC's Prevention Marketing Initiative (PMI). CDC staff members, including Bill Person (Assistant Director, HIV/ AIDS) and Lydia Ogden (P.M.I.) listened to the presentation of these demands and agreed to a 30 day time line for a response from your office.

The demands, once again, were:

1. Two young people must be appointed to the CDC Advisory Committee on the Prevention of HIV Infection.
2. We insist that CDC develop a plan to facilitate meaningful involvement of community members in planning CDC prevention initiatives. We regret that such input was not sought on PMI until the initiative had been developed and the television spots had aired.
3. CDC must develop a plan to facilitate the employment of two young people as liaisons to the affected and infected communities. Accordingly, one individual should be self-identified as a person living with HIV/AIDS. The second should be a sero-negative member of a high risk community.
4. CDC must establish an advisory board inclusive of young people from EVERY community affected by HIV/AIDS. This board will make recommendations to CDC on the goals

and management of federally controlled /managed surveillance and prevention efforts.

The above demands were prompted by the failure of yourself and your organization to create a clear and meaningful role for the young adult group at the meeting. As you have failed to acknowledge these demands or provide any response, we, the undersigned, consider the Washington D.C. meeting a complete waste of our time and limited federal dollars. Further, your failure to provide individual participants with a report on working group recommendations and CDC feedback, as promised, is inexplicable and outrageous.

Your failure to provide leadership and effective management for PMI or seek any input from affected and infected communities in the development process would be totally outrageous and unacceptable if this were the first such failure of yourself and your agency. We are well aware, however, that it is one of a long litany of failures in 12 years of CDC involvement in HIV/AIDS prevention.

PMI, furthermore, developed and implemented under your leadership, fails entirely to address young gay and bisexual men. As you know, gay and bisexual men remain the single largest risk group for HIV infection.

Under your leadership, CDC has amassed a track record of pitting community against community for funding and technical support of prevention programs. As Director of HIV/AIDS for CDC, it is your personal responsibility to insure that EVERY group at risk for HIV infection is targeted by thoughtful and effective prevention programs.

Please be advised that we, the undersigned, ARE NO LONGER WILLING TO WATCH YOU AND YOUR AGENCY FLOUNDER, DO NOTHING AND WASTE FEDERAL TAX DOLLARS AS WE, OUR FRIENDS, AND OUR LOVED ONES DIE. We insist that you respond to the demands we made at the March 3-4 meeting. Furthermore, we want broad, sweeping reform at CDC.

To this end, we are calling on the Secretary of Health and Human Services to terminate your employment as Director of HIV/AIDS at CDC. We feel that your silence, inaction and lack of leadership has already cost too many lives.

SIGNED:

TO SIGN ON TO THIS DOCUMENT, PLEASE CONTACT EDWARD ZOLD BY PHONE (415-252-8936) OR FAX (415-252-9277) BY NO LATER THAN APRIL 24, 1994.
INDIVIDUALS AND ORGANIZATIONS ARE WELCOME TO SIGN ON TO THIS DOCUMENT.

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, D.C. 20549

THE CHAIRMAN

RECEIVED
APR 18 1994

April 14, 1994

Kristine M. Gebbie, R.N., M.S.
National Aids Policy Coordinator
The White House
Executive Office of the President
Washington, D.C. 20503

Dear Ms. Gebbie:

I am pleased to learn that Mr. Lance Alworth has played an important role in your HIV and AIDS education effort.

As you requested, I have signed the enclosed Memorandum of Agreement. We have been very pleased to assist your program by assigning Mr. Alworth to temporary duty in your office. It is our understanding that you will not require Mr. Alworth's services beyond August 16, 1994. We have executed the enclosed Memorandum of Agreement based upon that understanding.

I wish you much success in your important project. Please feel free to contact Mr. Fernando Alegria, Associate Executive Director of the Office of Administrative and Personnel Management, (202) 942-4000 if you need additional information.

Sincerely,

Arthur Levitt

Enclosure

MEMORANDUM OF AGREEMENT
BETWEEN THE OFFICE OF THE NATIONAL AIDS POLICY COORDINATOR
AND THE U.S. SECURITIES AND EXCHANGE COMMISSION

I. PURPOSE

The purpose of this agreement is for the Securities and Exchange Commission (SEC) to provide for the temporary assignment of its employee, Mr. Lance Alworth, to the Office of the National AIDS Policy Coordinator (ONAPC).

II. BACKGROUND

The ONAPC has been designated by the President to provide government-wide leadership and direction to the Nation's efforts to combat the HIV and AIDS epidemic. The success of these efforts will require personnel possessing a broad variety of talents and experience. The National AIDS Policy Coordinator (NAPC) seeks to involvement and cooperation of each of the Federal government's Departments and independent agencies as partners in this effort. Optimal outcomes can be achieved through the temporary assignment of appropriate qualified personnel from federal operating organizations to work on projects and processes under the direction of the NAPC.

Mr. Alworth possesses broad experience and understanding of issues surrounding HIV and AIDS education. He has been active in the field of HIV and AIDS awareness for several years and is well suited to provide direction to a program to promote HIV and AIDS education within the Federal government. Mr. Alworth has demonstrated his high-level abilities in these realms by directing the development and implementation of such a program since mid-August.

III. GENERAL PROVISIONS

The SEC agrees to direct that Mr. Alworth's temporary duty station is the ONAP. During this period, he will remain an SEC employee and will be remunerated and covered by benefits in accordance with customary SEC policy. The ONAPC will cover any and all travel expenses incidental to the work which is conducted in behalf of the NAPC. ONAPC will make adjustments to travel and program schedules to accommodate periods which, from time to time, may require the employee to split his weekly work time between SEC functions and those of the ONAPC. Such schedules will be negotiated in advance. ONAPC will maintain and execute administrative documents which SEC may designate in support of the assignment.

IV. TERM OF AGREEMENT

This agreement takes effect when fully executed by both signatories and replaces any existing agreement. This agreement will be effective through August 16, 1994. The content, conditions, and/or term of this agreement can be modified at any time with the mutual written agreement of the signatories or their representative(s).

APPROVED AND ACCEPTED:

Arthur Levitt
Chairman
Securities and Exchange Commission

Date 4/14/94

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator
Executive Office of the President

Date April 1, 1994

THE WHITE HOUSE

WASHINGTON

April 15, 1994

RECEIVED
APR 18 1994

MEMORANDUM FOR WHITE HOUSE OFFICE STAFF

FROM: PATSY L. THOMASSON
SPECIAL ASSISTANT TO THE PRESIDENT AND
DIRECTOR OF THE OFFICE OF ADMINISTRATION

SUBJECT: "Take Our Daughters to Work Day"

We want to invite you to participate in the second annual "Take Our Daughters to Work Day" on April 28, 1994. This day, developed and promoted in conjunction with the Ms. Foundation, is designed to focus attention on young women ages 9-15. The Program's goal is to build a strong group of women and men committed to ending discrimination, loss of self-esteem and emotional distress in young women.

We are eager to have daughters throughout the White House Office (WHO) come to the Executive Office of the President (EOP) and take part in this exciting day. WHO parents are encouraged to bring their daughters to work. Daughters will spend the day observing their parents at work, and seeing the EOP in action.

Daughters will also have the exciting opportunity to participate in other planned activities. Participation in the planned activities will be limited. Please reserve your daughter's spot by completing the attached registration form and submitting it to the Personnel Management Division in Room 4013 of the New Executive Office Building no later than noon, April 21. Reservations will be filled on a "first come, first served" basis.

We look forward to seeing you and your daughters on April 28.

Attachment

750 17th St NW 1060
GEBBIE,KRISTINE M

DOMESTIC POLICY COUNCIL
WHO

TAKE OUR DAUGHTERS TO WORK

APRIL 28, 1994

EOP STAFF REGISTRATION FORM

My daughter would like to participate in the 9 a.m. kickoff session with Alexis Herman, Assistant to the President and Director for Public Liaison.

NAME:_____

DAUGHTER:_____ AGE:_____

OFFICE:_____

ROOM:_____ PHONE:_____ FAX:

Please send this registration form no later than noon, April 21, to the Personnel Management Division, Room 4013, NEOB or fax it to Mary Beck at 395-5608.

If you have any questions, please feel free to call the Personnel Management Division at 395-1088.

COMMENTS:

OFFICE OF CABINET AFFAIRS

THE WHITE HOUSE

WASHINGTON

FAX

TO: ASSISTANTS and DEPUTY ASSISTANTS TO THE PRESIDENT

DATE: 4/20/94

NO. OF PAGES 4 (Including cover)

PHONE: _____

FAX: _____

PRIORITY: (Y) N

FROM: STEPHEN SILVERMAN

PHONE: (202) 456-2572

FAX: (202) 456-6704



APR 20 1994

MESSAGE: _____

THE WHITE HOUSE

WASHINGTON

April 20, 1994

I hope this works

MEMORANDUM FOR DISTRIBUTION

FROM STEPHEN B. SILVERMAN
Deputy Secretary to the Cabinet

SUBJECT "Take Our Daughters to Work Day"

As a senior White House woman, you are invited to attend a luncheon reception on the South lawn in honor of "Take Our Daughters to Work Day" on April 28, 1994 at noon. At the luncheon you will dine at a table with ten young women from Cabinet agencies and local adopted schools, as well as daughters of White House staff members who will have spent the day at the White House.

This informal lunch, honoring Senior White House women, will give you the opportunity to interact with the young women, share your experiences and be acknowledged by the speaker for your accomplishments.

If you are able to attend the luncheon please fax the attached form to the Office of Cabinet Affairs at 6-6704, no later than 5:00 p.m. Thursday, April 21. We will make table assignments based on responses we receive by this deadline. The attached fact sheet provides other details about the day.

If you have any questions please do not hesitate to contact me at 6-2572. Thank you very much.

cc: Christine Varney
Ann Stock
Patsy Thomasson

FACT SHEET
"TAKE OUR DAUGHTERS TO WORK DAY"
APRIL 28, 1994

On April 28, 1994 the White House will host "Take Our Daughters to Work Day" for young women ages 9-15. White House staff will bring their daughters to work to observe their parents in action. Cabinet agencies have selected two young women to join us for the day to see life at the White House up close. The Departments of Labor, Health and Human Services and Education and the U.S. Secret Service have each selected ten young women from their local adopted schools to spend the day at the White House. Below is an outline of the days events.

8:30 am Young women arrive at the Old Executive Office Building.

9:00 am OPENING MEETING in room 450. Welcoming remarks will be given by Mrs. Clinton and Alexis Herman. We will also pay tribute to LaQuanda Edwards, a young woman who was killed in 1992, to whose memory this years "Take Our Daughters to Work Day" is dedicated.

10:00 am WHITE HOUSE SESSIONS - Interns will escort groups of ten young women to three White House Sessions given by Senior White House Staff in 20 departments.

Session I	10:10 am - 10:40 am
Session II	10:50 am - 11:20 am
Session III	11:30 am - 12:00 pm

12:00 pm WHITE HOUSE LUNCHEON - All groups will attend a luncheon on the South lawn with Senior White House women.

1:00 pm WHITE HOUSE TOUR

2:00 pm PROGRAM CONCLUDES

"TAKE OUR DAUGHTERS TO WORK"
LUNCH RECEPTION REGISTRATION

NAME_____DEPARTMENT_____

PHONE_____FAX_____

_____I will be attending the noon lunch.

_____I will not be able to attend the noon lunch

_____My biography is enclosed

Please fax to Stephen Silverman in the Office of Cabinet Affairs at 6-6704.

THE WHITE HOUSE

WASHINGTON

May 12, 1994

MEMORANDUM FOR WHITE HOUSE OFFICE STAFF

FROM: JOEL I. KLEIN JIK
DEPUTY COUNSEL TO THE PRESIDENT

W. NEIL EGGLESTON
ASSOCIATE COUNSEL TO THE PRESIDENT

RE: COMPLIANCE WITH THE MAY 4, 1994 GRAND JURY SUBPOENA

As was announced publicly last week, the White House has received a grand jury subpoena calling for certain records relating to Vincent W. Foster, Jr. In response to that subpoena, you are required to do the following:

I. DOCUMENTS THAT MUST BE PRODUCED

Each member of the staff of the White House Office must review any and all documents within that staff member's possession, custody, or control and produce responsive documents to the Counsel's Office. The documents that you must produce as of this time are:

1. All documents currently in your possession that were in the office of Vincent W. Foster, Jr. as of July 20, 1993.

2. Any indices, memoranda, notes or any other similar type of document listing, referring, or relating to documents and other items that were maintained by or within the office of Vincent W. Foster, Jr., while he was Deputy Counsel.

3. All documents written by, received from, or sent to Mr. Foster relating or referring to the Whitewater Development Company, Madison Guaranty Savings and Loan, or Capital Management Services, Inc.

Other documents in your possession, custody, or control relating or referring to Mr. Foster need not be produced at this time, but they must be maintained by you. (See III. below).

II. PROCEDURES FOR COMPLIANCE WITH THE SUBPOENA

The same general procedures employed by the White House to respond to the subpoena issued in March 1994 are to be followed in responding to this subpoena.

Please be reminded that the term "document" is defined quite broadly in the grand jury subpoena, and includes handwritten notes, electronic media, faxes and the like. In addition, the subpoena sets forth certain instructions for compliance, such as the necessity to produce originals and any copies of originals in your possession. We have attached the "Definitions and Instructions" section of the subpoena for ease of reference. Please read this section carefully to ensure that you are properly complying with the subpoena.

Attached to this Memorandum is a "Statement for All White House Staff Members," which requires a certification that the staff member has searched his or her documents for responsive materials. Please return this certification and any responsive documents to Marvin Krislov of the Counsel's Office (OEOB Room 128) by the close of business on Friday, May 13, 1994.

III. DUTY TO MAINTAIN DOCUMENTS RELATING OR REFERRING TO VINCENT W. FOSTER, JR.

On March 17, 1994, the Counsel's Office sent a memorandum directing staff members to retain all documents or computer files relating in any way to Vincent Foster. While we are not at this time requesting that all of these documents be provided to the Counsel's Office, you should be aware that the subpoena calls for "any and all documents and/or communications written by, sent to or referring or relating to Vincent W. Foster, Jr." As a result, all such documents must be maintained, and may not be destroyed.

IV. OTHER COMPLIANCE OBLIGATIONS

As before, we assume that this subpoena imposes a continuing obligation to provide responsive documents to the grand jury. Should you discover any possibly responsive documents at any time, you should notify Mr. Krislov immediately.

If you have any doubts whatsoever about the responsiveness of any document or record, it is your obligation to notify Mr. Krislov immediately. Any questions about this matter should be directed to Marvin Krislov at extension 6-7903 or Neil Eggleston at 6-7901.

# # #

Definitions and Instructions

1. Definitions

a. The term "document" or "documents" as used in this subpoena means all records of any nature whatsoever within your possession, custody or control, or the possession, custody or control of any agent, employee, representative, or other person acting or purporting to act for or on your behalf or in concert with you, including but not limited to memoranda, records, reports, notes, books, files, summaries or records of conversations, meetings or interviews, summaries or records of telephone conversations, diaries, calendars, datebooks, telegrams, facsimiles, telexes, telefaxes, electronic mail, computerized records stored in the form of magnetic or electronic coding on computer media or on media capable of being read by computer or with the aid of computer related equipment, including but not limited to floppy disks or diskettes, disks, diskettes, disk packs, fixed hard drives, removable hard disk cartridges, mainframe

computers, Bernoulli boxes, optical disks, WORM disks, magneto/optical disks, floptical disks, magnetic tape, tapes, laser disks, video cassettes, CD-ROMs and any other media capable of storing magnetic coding, microfilm, microfiche and other storage devices, voice mail recordings, and all other written, printed or recorded or photographic matter or sound reproductions, however produced or reproduced.

The term "document" or "documents" also includes any earlier, preliminary, preparatory or tentative version of all or part of a document, whether or not such draft was superseded by a later draft and whether or not the terms of the draft are the same as or different from the terms of the final document.

b. The term "communication" or "communications" is used herein in its broadest sense to encompass any transmission or exchange of information, ideas, facts, data, proposals, or any other matter, whether between individuals or between or among the members of a group, whether face-to-face, by telephone or by means of electronic or other medium.

c. "Possession, custody or control" means in your physical possession and/or if you have the right to secure or compel the production of the document or a copy from another person or entity having physical possession.

d. The term "referring or relating" to any given subject means anything that constitutes, contains, embodies, reflects, identifies, states, refers to, deals with, or is in any manner whatsoever pertinent to that subject including, but not limited to, documents concerning the preparation of other documents.

2. Instructions

a. If any original document cannot be produced in full, produce such document to the extent possible and indicate specifically the reason for your inability to produce the remainder.

b. Documents shall be produced as they are kept in the usual course of business, as organized in the files.

c File folders, labels and indices identifying documents called for shall be produced intact with such documents. Documents attached to each other should not be separated.

d. The originals of all documents and communications must be produced, as well as copies within your possession, custody or control.

e. In reading this rider, the plural shall include the singular and the singular shall include the plural.

f. The words "and" and "or" shall be construed

conjunctively or disjunctively as necessary to make the request inclusive rather than exclusive. The use of the word "including" shall be construed without limitation.

g. In the event that any document called for by this subpoena is withheld on the basis of any claim of privilege or similar claim, that document shall be identified in writing as follows: (a) author; (b) the position or title of the author; (c) addressee; (d) the position or title of the addressee; (e) any indicated or blind copies; (f) date; (g) a brief description of the subject matter of the document; (h) number of pages; (i) attachments or appendices; (j) all persons to whom the document, its contents, or any portion thereof, has been disclosed, distributed, shown or explained; and (k) present custodian. Each basis you contend justifies the withholding of the document shall also be specified. With respect to those documents or records as to which you may claim privilege, or attorneys' work product, set forth as to each such document the basis for such claim, the identity of each person who has been privy to such communication reflected in the document and whether you will submit the document to the Court for an in camera determination as to the validity of the claim.

i. In the event that any document called for by this subpoena has been lost, destroyed, deleted, altered, or otherwise disposed of, that document shall be identified in writing as follows: (a) author; (b) the position or title of the author; (c) addressee; (d) the position or title of the addressee; (e) indicated or blind copies; (f) date; (g) a brief description of the subject matter of the document; (h) number of pages; (i) attachments or appendices; (j) all persons to whom the document, its contents, or any portion thereof, had been disclosed, distributed, shown or explained; (k) the date of the loss, destruction, deletion, alteration or disposal and the circumstances thereof; (l) the reasons, if any, for the loss, destruction, deletion, alteration or disposal and the person or persons responsible.

j. If any information or data is withheld because such information or data is stored electronically, it is to be identified by the subject matter of the information or data and the place or places where such information is maintained.

THE WHITE HOUSE

WASHINGTON

Statement for All White House Office Staff Members

I hereby certify that, to the best of my knowledge and ability, I have provided all documents or communications responsive to the Memorandum for White House Office Staff of May 12, 1994 from Joel Klein and Neil Eggleston, "Compliance with May 4, 1994 Grand Jury Subpoena," within my possession, custody or control from my files and records (as set forth in the Definitions Section of the grand jury subpoena), including any from my electronic files. We have no documents.

I am not aware of the existence of any electronic mail communications or attachments that have not been produced or identified that are responsive to the May 12, 1994 Memorandum.

I ___ am ✓ am not producing documents responsive to the May 12, Memorandum.

Name: Andrew E. Barker
(Print)

(Sign)

Office: AIDS Policy

[Ms. Gebbie is on travel]

<px;;17>June 1994, Vol. 84, No. 6<pa>
<px;;18>Editorials<pa>
<px;;19>Editorials<pa><GP>

Delivered by messenger 9/12/94

A36

American Journal of Public Health

Department: Editorial

Month of issue: June 1994

Count: 7 pp

Running head: Editorials

Title:

edh1 Formulating Public Health Policy: The Case of AIDS (P)

~~(Text follows title)~~

tr to ms ↓ 7 ~~Author:~~

aut1 Kristine M. Gebbie <r>

ack1 The author is National AIDS Policy Coordinator.(P)
Requests for reprints should be sent to Kristine M. Gebbie, RN, MN, Office of National AIDS Policy, Executive Office of the President, 750 17th St, NW, Suite 1060, Washington, DC 20503 (P)

<BDS> Editor's Note. # <BDE> See related article by Robins and Backstrom (p ooooo) in this issue.

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key bullets

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Both law and good practice dictate some combination of consultation, oversight or concurrence from interested parties, advisory or decision-making health boards, elected officials, or legislators.

HIV infection and AIDS arrived on the public health policy scene early in the last decade, and presented multiple challenges to an already strained public health system. Budget tightening due to a recession had restricted state and local appropriations. The "new Federalism" of the Reagan years included the merging of many public health programs into block grants for greater local flexibility, but an associated cut of approximately 25% of funds made it nearly impossible to sustain activities. Efforts to increase the levels of school immunization, respond to the public interest in safe drinking water, reduce toxic wastes, improve birth outcomes, and increase access to basic primary health care are examples of the many demands on public health officials.

Then came reports of a new syndrome, probably viral in origin, which was spreading rapidly and causing great public concern. The initial concentration of cases in a few geographic areas and population groups allowed many states to frame the issue as primarily of academic interest. Soon, however, the public outcry

for action became nationwide. Usual procedures "Business as usual" (epidemiological investigation of reported cases, consultation with the Centers for Disease Control and Prevention, distribution of updated information to key clinical and diagnostic centers) was swept away or confused by strong emotional responses. Advocates in the community most affected initially, gay men, argued strongly that the issue was ignored because of homophobia and that traditional record keeping or case identification methods would too easily support a variety of repressive, discriminatory or inappropriate control measures. Public fear of a devastating, community-wide disease explosion pushed others' voices to call for more stringent measures, based on historical (and not scientifically supportable) public health measures such as isolation, quarantine and public notification.

The study by Robins and Backstrom in this issue of the Journal was designed to identify the degree to which public health agencies were have been effective leaders in developing AIDS-related policies at the state level. The authors refer extensively to the Institute of Medicine study of public health published in 1988,[2] which viewed "with great concern and some alarm. . . the current state of public health." This report indicated that a lack of leadership, tightly constrained resources, and limited vision were preventing the public health infrastructure of the nation

au: is this note 8 from the IOM report (or Robins?) from IOM, cited

from asserting a proper role in protecting the public from disease and promoting a healthier nation.

Robins and Backstrom, on the other hand, conclude that, at least in the case of AIDS, "public health departments are very influential [and] . . . promoted their ideas with a clear understanding of their political environments and the strategies appropriate in them." Their analysis of this different conclusion was at least in part that the Institute of Medicine used faulty criteria, focusing on failures to provide leadership and vision in areas which were beyond the scope of currently structured state health agencies. In using a case more in the mode of classic governmental public health responsibilities, namely, response to a communicable disease, appropriate leadership was found.

The study reported has some unusual features, at least in the context of understanding state policies regarding HIV infection and AIDS. Debate about this condition at all levels of government has included an extremely visible role for advocacy groups emerging out of those most affected by the epidemic. These include gay and lesbian rights and civil rights groups, and new associations focused exclusively on HIV issues, such as the AIDS Coalition to Unleash Power (ACT-UP), Gay Men's Health Crisis, and the National Minority AIDS Council. In two

states included in the reported study, New York and California, early legislative action regarding documentation and reporting of HIV-related information went in a direction contrary to traditional public health practice, and appeared not to stem from leadership activities by the state health officials.

The information on study methodology indicates that the sources of data were state health officials themselves, chairs of health committees in state legislatures, and officials of hospital associations (apparently as a representative lobbying group). Given the interest of HIV advocacy groups, which emerged early in the epidemic, it would have been most appropriate to include at least some representative of that perspective in the study. One might expect that their views would be more critical of the role played by public health officials.

Further, in at least some states, the issues of legal restriction on HIV positive individuals were reviewed in committees other than the health committee, such as a committee on legal affairs. Yet only health committee chairs were surveyed. It would have been helpful to know whether the responding committee had actually had jurisdiction over and considered legislation relevant to quarantine or isolation during the relevant time period. If the health committee had not sponsored hearings on these matters, or had performed only a secondary role in bill

development, the health committee chair's understanding of the relative roles of interest groups and agencies might be limited.

An additional concern in data presentation is the question of which states responded. While it is possible that among the 42 state health departments, 39 hospital associations and 43 legislatures represented in the responses was at least one reply from every state, that is not made clear. In this particular policy area, the experiences of the states with high early infection rates had an enormous impact on the nation as a whole, and the relative roles of state health officials, legislatures and advocacy groups were shifted depending on whether early public or advocacy excitement rushed a legislature to action or whether there was time to develop a proposal more slowly.

It is very important, in the face of both the continuing HIV epidemic and the potential for major health system reform, that the nation's state health officials play an appropriate role in determining policies which can promote the health of the public and protect the nation from preventable conditions. The literature on the public policy role of health officials is sparse, and a great many senior health officials in this country have learned about policy development on the job. Critical reading of articles such as that by Robins and Backstrom can enlarge our understanding of the interplay of interest groups and

provide direction in how to communicate both concerns and successes to a wider audience. One would hope that others reading this piece will be stimulated to add to the body of literature, whether with a second generation of survey materials or well-developed case studies. Such a literature can assist us all in appreciating both what has been the experience in public policy in the case of HIV and AIDS, and what might be expanded within the broad role available to a state health official. <obox>

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[illegible] (P) [illegible] L . [illegible] C ⊙ The Role of state health departments in formulating policy: a survey on the case of AIDS ⊙ Am J Public Health ⊙ 1994; 84:[illegible].

(P) [illegible] ⊙ The Future of Public Health. Washington, DC: National academy Press; 1988.

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Formulating Public Health Policy: The Case of AIDS

As is true in many areas of American life, public health policy formulation is not a tidy process. All levels of government are involved: federal, state, and local. At all these levels legislative bodies have been inconsistent in the breadth of power granted to executive agencies.

In some instances, statutory language is broad and grants agencies wide authority to define issues, prescribe public action, or direct staff attention to a public health official. In other instances, laws go into great detail on specific conditions or circumstances to which a particular action applies, and the opportunity for public health officials to use their judgment in individual applications is very limited.

Federal policies may supersede state and local ones and states may manage or strongly influence local actions, but the chain of command is not direct. Funding for most public health activities is shared among the levels of government, and money may be granted only in exchange for certain actions. Local actions are often constrained or directed by commitments made in order to gain access to funds available from the state or federal level. In few cases does a public health official simply "make policy." Both law and good practice dictate some combination of consultation, oversight, and concurrence by interested parties, advisory or decision-making health boards, elected officials, or legislators.

Human immunodeficiency virus (HIV) infection and acquired immunodeficiency syndrome (AIDS) arrived on the public health policy scene early in the last decade and presented multiple challenges to an already strained public health system. Budget tightening as a result of a recession had restricted state and local appropriations. The "new Federalism" of the Reagan years included the merging of many public health programs into block grants for greater local flexibility, but an associated cut of approximately 25% of funds made it nearly impossible to sustain activities. Efforts to increase the levels of school immunization, respond to the public's interest in safe drinking water, reduce toxic wastes, improve birth outcomes, and increase access to basic primary health care were among the many demands facing public health officials.

Then came reports of a new syndrome, probably viral in origin, that was spreading rapidly and causing great public concern. The initial concentration of cases in a few geographic areas and population groups allowed many states to frame the issue as one of primarily academic interest. Soon, however, the public outcry for action became nationwide. Usual procedures (epidemiological investigation of reported cases, consultation with the Centers for Disease Control, distribution of updated information to key clinical and diagnostic centers) were swept away or confused by strong emotional responses. Advocates in the community most affected initially, gay men, argued strongly that the issue was ignored because of homophobia and that traditional record keeping or case identification methods would too easily support a variety of repressive, discriminatory, or inappropriate control measures. Public fear of a devastating, communitywide explosion of disease pushed other voices to call for more stringent measures, based on historical (and not scientifically supportable) public health measures such as isolation, quarantine, and public notification.

The study by Robins and Backstrom in this issue of the Journal was designed to identify the degree to which public health agencies have been effective leaders in developing AIDS-related policies at the state level.[1] The authors refer extensively to the Institute of Medicine report on public health published in 1988,[2] which viewed "with great concern and some alarm ... the current state of public health." This report indicated that a lack of leadership, tightly constrained resources, and limited vision were preventing the public health infrastructure of the nation from playing its proper role in protecting the public from disease and promoting a healthier nation.

Robins and Backstrom, on the other hand, conclude that at least in the case of AIDS, "public health departments are very influential [and have] promoted their ideas with a clear understanding of their political environments and the strategies appropriate in them." Their explanation of this difference in conclusions was that the Institute of Medicine, at least in part, used faulty criteria, focusing on public health's failures to provide leadership and vision in areas that were beyond the scope of currently structured state health agencies. In using as a reference point a case more in the mode of classic governmental public health responsibilities, namely, response to a communicable disease, Robins and Backstrom found appropriate leadership by public health agencies.

Robins and Backstrom's study has some unusual features, at least in the context of understanding state policies regarding HIV infection and AIDS. Debate about these diseases at all levels of government has included an extremely visible role for advocacy groups emerging from the communities most affected by the epidemic. These include gay and lesbian rights and civil rights groups and new associations focused exclusively on HIV issues, such as the AIDS Coalition to Unleash Power (ACT-UP), Gay Men's Health Crisis, and the National Minority AIDS Council. In two states included in the reported study, New York and California, early legislative action regarding documentation and reporting of HIV-related information went in a direction contrary to traditional public health practice and appeared not to stem from leadership activities by the state health officials.

Robins and Backstrom indicate that their sources of data were state health officials themselves, chairs of health committees in state legislatures, and officials of hospital associations (apparently included as a representative lobbying group). It would have been most appropriate to include at least some representatives of HIV-issue advocacy groups in the study. One might expect that their views would be more critical of the role played by public health officials.

Further, in at least some states, the issue of legal restrictions on HIV-positive individuals was reviewed in committees other than the health committee, such as a committee on legal affairs. Yet only health committee chairs were surveyed. It would have been helpful to know whether the health committee had actually had jurisdiction over and considered legislation relevant to quarantine or isolation during the relevant time period. If the health committee had not sponsored hearings on these matters, or if it had performed only a secondary role in bill development, the health committee chair's understanding of the relative roles of interest groups and agencies might be limited.

An additional concern is the question of which states responded. While it is

Author: see query on p. 1, 3, 4, 5

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possible that among the 42 state health departments, 39 hospital associations, and 43 legislatures represented in the responses there was at least one reply from every state, it is not made clear whether this was the case. In this particular policy area, the experiences of the states with high early infection rates had an enormous impact on the nation as a whole, and the relative roles of state health officials, legislatures, and advocacy groups shifted depending on whether early interest by the public or advocacy groups rushed a legislature to action or whether there was time to develop a proposal more slowly.

It is very important, in the face of both the continuing HIV epidemic and the potential for major health system reform, that the nation's state health officials play an appropriate role in determining policies that can promote the health of the public and protect the nation from preventable conditions. The literature on the public policy role of health officials is sparse, and a great many senior health officials in this country have learned about policy development on the job. Critical reading of articles such as the one by Robins and Backstrom can enlarge our understanding of the interplay of interest groups and provide direction in how to communicate both concerns and successes to a wider audience. One would hope that others reading this piece will be stimulated to add to the body of literature, whether with a second generation of survey materials or with well-developed case studies. Such a literature can assist us all in appreciating both what has been the experience in public policy in the case of HIV and AIDS and what might be expanded within the broad role available to a state health official. □

Kristine M. Gebbie

The author is National AIDS Policy Coordinator.

Requests for reprints should be sent to Kristine M. Gebbie, RN, MN, Office of National AIDS Policy, Executive Office of the President, 750 17th St, NW, Suite 1060, Washington, DC 20503.

Editor's Note. See related article by Robins and Backstrom (p ●●●●) in this issue.

References

1. Robins L, Backstrom C. The role of state health departments in formulating policy: a survey on the case of AIDS. *Am J Public Health.* 1994;84:●●●–●●●.
2. Institute of Medicine. *The Future of Public Health.* Washington, DC: National Academy Press; 1988.

Author: see query on p_____

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Enclosed should be your original manuscript (now copyedited), our typeset version of the manuscript ("page proofs"), and a reprint order form. If any of these are missing or you have received something in error, please contact us immediately. **We ask that you complete your review of your page proofs within 48 hours of receiving them.** Even if you have no changes, you must sign and return the proofs. Failure to return the proofs will result in a delay in publication.

Although we do not require that you send us your reprint order with the proofs, for the most prompt service return the order form and payment as soon as possible.

Please note that the contents of your paper are embargoed (i.e., the paper's essential results must not be reported by or discussed in the media before a certain date, which may be as late as the middle of the month of issue). If you need to know the exact embargo date, contact Sabine J. Beisler at (202) 789-5663. If you would like to coordinate your public relations activities with ours, contact Rachel Dale at (202) 789-5677.

Please follow the guidelines below in reviewing your page proofs. **Limit your changes to correcting inaccuracies and answering editorial queries.** You will be charged for the cost of excessive changes. If you have any questions during your review, contact Anne Mattison at (202) 789-5682.

1. First, proof the typeset pages against the original manuscript, including--and especially--tables and references. Use red or blue ink to mark any corrections clearly in the margins (see the proofreaders' marks on the reverse side of this sheet). Place as many corrections as possible on the page proof. If space is limited, type corrections on a separate sheet of paper and label them Insert A, B, C, etc., with their placement indicated on the page proof. (If you need to refer us to a passage in your original manuscript, write "see ms" on the proof at the appropriate place.) Please be sure all changes are indicated in some manner on the page proof.
2. Address any queries from the copyeditor or typesetter that have been written in the margins of the manuscript and are indicated by arrows on the page proofs. If you need to provide explanations or more detail for your changes, place these in a cover letter or on the manuscript.
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Thank you for your contribution to the Journal!

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^	Semicolon
✓	Apostrophe
“	Open quotes
”	Close quotes
=	Hyphen
⊣ ⊣ ⊣	Dash (show length)
( )	Parentheses

DELETE AND INSERT	
⌒	Delete
⌒	Delete and close up
omit see copy	Insert omitted matter
stet	Let it stand

PARAGRAPHING	
¶	Paragrapn
fl ¶	Flush paragraph || 1	2	Indent (show no. of ems)
run in	Run in

POSITION	
⊐ ⊏	Move right or left
⊓ ⊔	Raise, lower
ctr	Center
fl L fl R	Flush left, right
=	Align horizontally
‖	Align vertically
tr	Transpose
tr #	Transpose space

SPACING	
#	Insert space
eq #	Equalize space
⁀	Close up

STYLE OF TYPE	
wf	Wrong font
lc	Lower case
cap	Capitalize
u lc	Initial cap, then lower case
sc	Small capitals
c sc	Initial cap, then small caps
rom.	Set in roman
ital	Set in italics
lf	Set in light face
bf	Set in bold face
✓	Superior character
^	Inferior character

MISCELLANEOUS	
X	Broken type
⌒	Invert
⊥	Push down
sp	Spell out
/	Shilling mark (slash)
...	Ellipsis
see l/o	See layout
? query	Query

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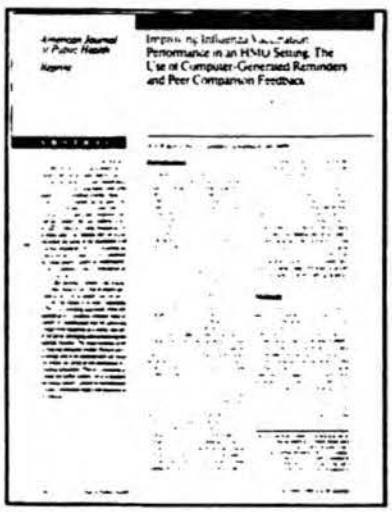
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THE FEDERAL CENTERS FOR DISEASE CONTROL AND PREVENTION IN ATLANTA WILL CONFIRM THESE MEDICAL FACTS:

file

1. Haitians are a MAJOR HIGH RISK AIDS AND HIV GROUP.

2. Haitians with AIDS are highly susceptible to Pneumocytis carinii Pneumonia, Toxoplasma Gondii Mycobacterium TUBERCULOSIS, Cytomegalovirus (CMV), Epstein-Barr virus (EBV), Herpes Simplex virus (HSV), Mycobacterium Avium - Intracellulare, Salmonella, Cryptococcus, Neoformans, sexually transmitted diseases (STD 5), which are highly contagious and are deadly killing diseases.

3. Haitians with AIDS and Tuberculosis will spread Tuberculosis, which is a highly contagious airborne disease spread by coughing, sneezing, and breathing , and will infect American men, women and children who will suffer and die.

In 1989 and 1990 for example, a worker at the Bath Iron Works, a shipyard in Bath, Maine, infected 417 co-workers with Tuberculosis in eight months. And this Tuberculosis epidemic happened in a small New England city with no previous Tuberculosis said Dr. Ban Mishu, an Epidemiologist at Vanderbilt University. Source of this information: News article by Peter Kilborn, Special to the New York Times, Washington, January 22, 1994. Additionally, this news article states: In Arkansas, Dr. William Stead, Arkansas top Tuberculosis Official, said that in late 1992 a woman with Tuberculosis, who worked in a chicken processing plant, infected hundreds of children and men and women with Tuberculosis.

4. Haitians with Pneumonia and AIDS will spread Pneumonia, which is A HIGHLY CONTAGIOUS airborne disease by coughing , sneezing, and breathing, and they will infect American men, women, and children, who will suffer and die.

5. A much worse situation is that an ANTHRAX epidemic broke out in Haiti in 1993. Source of this information: The New York Times Medical Science, May 10, 1994, Centers for Disease Control and Prevention. Haitians with Anthrax will spread Anthrax, which is A HIGHLY CONTAGIOUS DEADLY DISEASE, and they will infect American men, women, and children, who will suffer and die.

President Clinton, stop playing politics and doing what's best for yourself. This is strictly a health issue. Do what's best for America and keep your sacred promise, AND OATH OF OFFICE, to God and the American people.

AMERICA

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JUN - 6 1994

APHA
American Public Health Association

1015 Fifteenth Street, NW
Washington, DC 20005
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June 2, 1994

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator
The White House
1600 Pennsylvania Avenue, NW
Washington, DC 20500

Dear ~~Ms. Gebbie:~~ Kris,

Thank you for supporting the nomination of William H. McBeath, MD, MPH, LLD, for the 1994 Sedgwick Memorial Medal, one of the highest honors bestowed by the American Public Health Association. Please be assured all nominees were given every consideration by the Awards Committee. The winner will be announced in *The Nation's Health* shortly before the Annual Meeting. We appreciate your assistance and contribution towards the conduct of this year's award program.

Sincerely,

Katherine S. McCarter

Katherine S. McCarter, MHS
Associate Executive Director/Programs & Policy

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Dear Author:

We are sending you copies of the *Journal* issue in which your article appeared. If there were co-authors, please send them each one copy. Thank you for your help.

Sincerely,

Sabine J. Beisler
Assistant Managing Editor

1. Summary. The GOF convened an intergovernmental meeting June 17-18 in Paris to prepare for the proposed "Paris Summit on AIDS" on World AIDS Day, December 1. At an April intergovernmental meeting it was decided that the December 1 meeting would be at the "highest appropriate level," consistent with the substance of the preparatory work. From the outset of the June 17-18 meeting, however, the GOF and other governments, particularly developing countries, referred to the December 1 meeting as a Heads of Government meeting, thus ignoring completely the April 8 recommendation. The meeting agenda, which reflected the obvious intent of the GOF and the WHO, the co-organizer, to host a Heads of Government meeting, allowed no time for debate on the level of participation. The U.S. stressed the need to build on the progress made at the April 8 meeting on both the level of the December 1 meeting and the organization of the preparatory work. The U.S. was supported by many delegations on the organizational comments but received little support during plenary for a more careful consideration of the level of participation at the December 1 meeting. In side discussions, several delegations noted that they took a dim view of the summit but would not oppose Mme. Veil publicly on the grounds of inter-European politics. The GOF informed us that they would be sending out invitations to a Heads of Government meeting on December 1 in the coming week. End Summary.

2. Diplomatic meetings held on June 16.

Meeting with Ambassador Harriman. USdel met briefly with Ambassador upon arrival in Paris to discuss the overall U.S. approach to the meeting.

Meeting with Mme. Veil, Minister of State and Presider of the June 17-18 meeting. Head of delegation Gebbie, Patricia Fleming, Special Assistant to Secretary Shalala and Tony Dalsimer, Labor Attache and AIDS contact at embassy Paris, met with Mme. Veil for one half hour. This was the only meeting Mme. Veil would have with any of the delegations prior to the meeting. Ms. Fleming delivered a letter from Secretary Shalala regretting the invitation to attend the meeting. Mme. Veil, whose depth of concern for the AIDS issue was apparent, spoke to the immensity of the global AIDS problem. The U.S. delegates concurred but noted that calling a Heads of Government meeting or other high-level meeting might raise the expectations of developing countries at a time when assistance budgets are severely constrained. The U.S. delegates noted further that the U.S. was already the major contributor to AIDS efforts and would urge other governments to do more. The group discussed possible action items which could be included in a Declaration for the December 1 meeting. The meeting closed with Gebbie's statement that the U.S. would base its recommendation for the "highest appropriate level" of participation at the December 1 meeting on the preparatory work. Both Ms. Gebbie and Ms. Fleming received flowers from Mme. Veil subsequent to their meeting.

emphasizing the need for substance in the science work.

Meeting with Ambassador Lunven, Diplomatic Coordinator, MFA. USdel and ESTOFF Boice met with Ambassador Lunven to outline the U.S. position, stressing the need to build on the April 8 meeting, to determine the appropriate level of participation at the December 1 meeting based on the preparatory work, both from the immediately forthcoming meeting and subsequent work before December, and to work to ensure that any high level meeting on December 1 should be an effective effort in the fight against AIDS. Ambassador Lunven had little response.

3. Preliminaries.

Madame Veil presided over most of the day and half long meeting. Her opening comments included a discussion of the gravity of the global AIDS situation, giving special emphasis to the increasing rates of infection in women. She called for "optimizing coordination." As an unexpected procedural change, Mme. Veil announced that Dr. Hedi M'Henni, Minister of Public Health in Tunisia, would act as co-chair of the meeting. Unlike the April meeting, Ambassador Lunven played little role in the work. Michael Merson, Director of the WHO's Global Programme on AIDS, emphasized the need for human rights consideration and the need for persons with AIDS to participate in the "Paris Summit."

Three "witnesses" spoke briefly: a person infected with HIV, an NGO representative from Zaire and Luc Montagnier, France's premier AIDS researcher, who called for stepping up research efforts to combat the spread of AIDS.

4. Opening Statements. Kristine Gebbie, head of the U.S. delegation, read the Opening Statement, whose content was accepted by all delegates and an interagency group prior to the trip, early in the session. The Statement stressed:

1) building on the progress made at the April 8 meeting (REFTEL) by using the six agreed principles as the point of departure of the present discussions

2) Organizing the document to be used on World AIDS Day according to the existing WHO AIDS strategy, thus avoiding the creation of a new strategy

3)Close cooperation with the UN system and its efforts to re-structure the AIDS effort

4)Reminding the group that at the April 8 meeting all 17 countries agreed that the December meeting should be at the "highest appropriate level" which would be determined based on the preparatory work before December

5)Proposed that a review mechanism for documents to be used at the December 1 meeting be established to ensure that governments would be prepared to participate fully at the December 1 meeting.

Several delegations supported the comments made by the U.S. regarding building on the principles of the April 8 meeting and in organizing the work according to the WHO strategy on AIDS (Sweden, Australia, China, Netherlands, Norway). However, only Sweden and the Netherlands stated that they were not in the position to consider a Heads of Government meeting on December 1. Other governments either did not reference the level of the December meeting or the agreement on April 8 or specifically referred to a Heads of Government meeting (all developing countries, Denmark, Belgium). Comment: In side discussions, several governments, including Denmark, the U.K. and Germany agreed with the U.S. in that the preparatory work to this point did not/not justify a Heads of Government meeting but noted that political reasons prevented them from opposing Mme. Veil, one of the most respected politicians in Europe and possibly the next Prime Minister. Delegates from other donor countries praised the U.S. and Ms. Gebbie on the interventions but seemed resigned to an inevitable Heads of Government meeting. The degree of support for Ms. Gebbie's comments was demonstrated by the spontaneous applause which broke out after an intervention to attempt to remedy a procedural issue. End comment.

Opening Statements of many developing countries focussed on the need to develop a vaccine, improve blood safety, and improve access to health services, particularly for the treatment of other sexually-tranismitted diseases. Some called for the establishment of a fund by wealthy countries to be used for vaccine development.

5. Technical working meetings. US delegates were unsuccessful in changing the meeting agenda such that technical discussions would be held in plenary rather than separate working groups. The USdel split to cover different themes. In general, the U.S. proposed keeping the technical discussion as general as possible for the sake of the proposed high-level political participant at the December 1 meeting. The recommendations produced in the 1-hour sessions on each of the 5 themes (list) will:

and emphasizing true policy issues

avoiding detailed technical

Be sure to use the full name of the vaccine & other issue groups

serve as the point of departure for subsequent working level discussions

will be fit into the framework of the 3 main areas of the existing Global Strategy on AIDS.

6. The communique. The process of generating the communique reflected the general manner in which the meeting was conducted and organized, i.e. developed by the GOF and the WHO with little input from concerned governments. Only the U.S. delegation received a draft copy of the final communique, one hour before it was scheduled to be released to the press. The U.S. called for a break so that other governments could examine the draft and upon re-convening make editorial changes. During the break, the U.S., with support from Australia and (Netherlands-check) successfully negotiated the change in the

communique to exclude references to "new forms of cooperation" and commitment to the issue from "the highest level" at the Paris meeting. We were not successful in changing references to the "Paris Summit", since the French noted that the term "summit" for them meant a "conference" and since it was their sovereign right to call a conference at whatever level they deemed appropriate. During Plenary, the hard copy of the communique was not distributed for review by all governments nor was there opportunity to voice much criticism of the draft.

7. Comment. It is clear that the GOF intended to ~~convene a~~ invite Heads of Government to meeting on AIDS on December 1 before the USdel arrived in Paris on June 16. We will step up our diplomatic efforts with other governments and with the WHO to develop substantive points to which the U.S. can agree at the December 1 meeting. End comment.

During final discussions with Mme Veil and Mike Merson (GPA) Ms Gebbie again strongly emphasized the need for collaborative advance work for the December meeting, with a first draft of any proposed declaration(s) available by the end of the summer, to allow for adequate review and consultation.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Office of the Assistant Secretary
for Health
Washington DC 20201

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Tom Valverde
President
Hispanic AIDS Coalition of
Greater Kansas City
1333 South 27th Street
Kansas City, Kansas 61106

Dear Tom,

Thank you for your letter of May 25th regarding AIDS positions in the Regional Offices. Along with our Regional Health Administrators, we are currently reviewing various functions to be performed in the Regional Offices. I will bring your letter to their attention as well as that of Dr. Jo Boufford, my Principal Deputy, who is working closely with me on this. I will also send a copy to Kristine Gebbie, the Aids Coordinator in the White House.

I appreciate your assistance.

Sincerely,

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

cc: Dr. Jo Boufford
Kristine Gebbie

full

United States Department of State

Washington, D.C. 20520

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PLEASE DELIVER THE FOLLOWING PAGES TO:

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Office: National AIDS Program Office

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Office: Population

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NOTES:

Thank you for returning my call. FYI, I am sending the relevant portion (Section 3) of the 7th UN Population Inquiry and the response from the Nat AIDS Progr Off. to items 308-314. A question: in the response to #312, the term "multi-epidemic" is used. Is this a common term used to describe the HIV/AIDS epidemic and what does it mean? Lastly, could you please send us a second copy of both the Surgeon General's Rpt. on AIDS & the Strategic Plan to Combat HIV & AIDS in the U.S.

We will send one copy to the UN along with the completed survey and keep one for our Bureau.

Thank you.

Monika Naegeli
(Pres. Mgmt Intern)

SEVENTH UNITED NATIONS POPULATION INQUIRY AMONG GOVERNMENTS

MONITORING OF GOVERNMENT PERCEPTIONS AND POLICIES ON DEMOGRAPHIC TRENDS AND LEVELS IN RELATION TO DEVELOPMENT, 1992

United Nations
New York

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SECTION 1. INTRODUCTION

101. The World Population Plan of Action, adopted by the United Nations World Population Conference in 1974 at Bucharest, recommended in paragraph 107 that "monitoring of population ... policies discussed in this Plan of Action should be undertaken continuously as a specialized activity of the United Nations ..."[1]. In paragraph 108, it recommended that a "comprehensive and thorough review and appraisal of progress made towards achieving the goals and recommendations of this Plan of Action should be undertaken every five years by the United Nations system". These recommendations were re-affirmed in the Recommendations for Further Implementation of the World Population Plan of Action adopted by the International Population Conference in Mexico City in 1984.[2] This Seventh Inquiry is being carried out as a measure toward the achievement of these recommendations and as specifically requested by the Economic and Social Council in its resolution 1991/92 on the work programme of the United Nations in the field of population.

102. Earlier reviews and appraisals of progress made towards implementation of the World Population Plan of Action were undertaken in 1979, 1984 and 1989. The information to be derived from the Seventh Inquiry will make a vital contribution to the report on the fourth review and appraisal of population policies to be prepared for 1994. Replies to the Inquiry will be analysed and the findings will provide significant input into the substantive preparations for the International Conference on Population and Development, 1994. That Conference aims to contribute a review and appraisal of progress made towards achieving the World Population Plan of Action and to its further implementation, including, as necessary, making goals and recommendations of the appropriate modifications of those goals and recommendations.

103. Terminology and concepts used in this Inquiry are identical with those used in the World Population Plan of Action.

104. Replies to this Inquiry should be sent by 1 October 1992, to the Director of the Population Division of the United Nations Secretariat at the address shown in 105 below.

---

[1] *Report of the United Nations World Population Conference, 1974, Bucharest, 19-30 August 194* (United Nations publication Sales No. E.75.XIII.3), chap. I, para. 107.

[2] *Report of the International Conference on Population, 1984, Mexico City, 6-14 August 1984* (United Nations publication, Sales No. E.84 XIII 8 and corrigenda), chap. III, sect. C, recommendation 88.

105. If, in the course of responding to this Inquiry, the Government finds that further clarification is needed, the Government is invited to call upon either:

The Director
Population Division
United Nations Secretariat
New York, N.Y. 10017, USA

or

The UNFPA Country Director
United Nations Development Programme
(at its office serving your country)

or the appropriate United Nations regional commission, as follows:

Head, Population Activities Unit
Economic Commission for Europe
Palais des Nations,
1211 Geneva 10, Switzerland

Chief, Population Division
Economic and Social Commission for Asia and the Pacific
United Nations Bldg., Rajdamnern Avenue, Bangkok, Thailand

Director, Latin American Demographic Centre (CELADE)
Economic Commission for Latin America and the Caribbean
Avenida Dag Hammarskjold,
Casilla 179-D, Santiago, Chile

Chief, Population Division
Economic Commission for Africa
P.O. Box 3001, Addis Ababa, Ethiopia

Chief, Social Development and Population Division
and Human Settlements Division
Economic and Social Commission for Western Asia
Amman, Jordan

106. For purposes of clarification, it will be most helpful if the Office chiefly responsible for the preparation and/or coordination of responses to this Inquiry is identified (please provide full name and address of office):

_____

_____

SECTION 3. MORTALITY

301. What is the view of the Government concerning the present expectation of life at birth?

1. ☐ Acceptable
2. ☐ Not acceptable
3. ☐ No official position

302. What is the view of the Government concerning the present level of infant (aged less than one year) and child (aged 1-5 years) mortality?

1. ☐ Acceptable
2. ☐ Not acceptable
3. ☐ No official position

303. Has the Government specified quantitative targets for mortality levels?

1. ☐ No (Go to 305)
2. ☐ Yes

304. Please indicate target levels and dates for achievement.

_____

_____

305. Has the Government identified any specific population groups whose mortality levels are of particular concern? (For example: any group(s) by age, sex, occupation, income, region)

1. ☐ No (Go to 307)
2. ☐ Yes

306. Please specify groups whose mortality level is of particular concern.

_____

307. Please specify any conditions or diseases that are currently of major concern from the standpoint of mortality policy.

_____

_____

308. What is the viewpoint of the Government regarding acquired immune deficiency syndrome (AIDS) in the country?

1. ☐ Not a concern
2. ☐ Minor concern
3. ☐ Major concern

309. Has the Government adopted special measures to prevent or reduce the occurrence of AIDS?

1. ☐ No (Go to 311)
2. ☐ Yes

310. Please specify the measures taken.

_____

_____

311. What is the experience of the Government with regard to the availability of resources needed to address AIDS?

1. ☐ No difficulties, sufficient resources available (Go to 313)
2. ☐ Minor difficulties, some additional resources needed
3. ☐ Major difficulties, substantial additional resources needed

312. Please indicate the nature and extent of the difficulties encountered.

_____

_____

313. Has the Government placed restrictions on the entry into the country of people (immigrants, migrant workers, students, refugees and asylum-seekers, return migrants, tourist(s) infected with the AIDS virus?

1. ☐ No (Go to 315)
2. ☐ Yes

314. **Please specify the measures taken.**

315. **The Government is invited to provide to the United Nations a copy of any official statement, legislation, regulation, decree, judicial decision, planning document or other official formulation issued since 1 January 1985 referring to any substantial changes in:**

-- **access and availability of health services to the public, including medical insurance arrangements;**

-- **licensing, training and control of medical practitioners, para-medical or other health-service personnel;**

-- **implementation of programmes in public health;**

-- **implementation of programmes in health education and information.**

316. **The Government is invited to provide a statement concerning any aspect of its policies, programmes or priorities in reference to morbidity or mortality. In this connection the Government may wish to consider the goals and recommendations on mortality, morbidity and health care of the World Population Plan of Action adopted by the United Nations World Population Conference, 1974, as well as the recommendations adopted by the International Conference on Population, 1984 (see paras. 20-26 of the World Population Plan of Action and recommendations 14-24 of the *Report of the International Conference on Population, 1984, Mexico City, 6-14 August 1984.***

Note: If more space is needed, please attach a sheet marked "Supplementary to 316".

Included in the Strategic Plan Appendix is an overview of all Federal AIDS programs and activities and total dollar expenditures.

The Public Health Service is the lead agency for monitoring the goals contained in Healthy People 2000: National Health Promotion and Disease Prevention Objectives (TAB B). The document is a national strategy for significantly improving the health of the Nation over the coming decade. It addresses the prevention of major chronic diseases, injuries and infectious diseases. HIV infection is recognized as one of the Nation's priorities for health promotion and disease prevention and is addressed by a specific goal with corresponding supporting objectives.

The National Commission on AIDS was established by public law "for the purpose of promoting the development of a national consensus on policy concerning AIDS and of studying and making recommendations for a consistent national policy." In existence for four years, the Commission published 13 interim reports which addressed such HIV/AIDS related issues as the impact on rural America, correctional facilities, substance abuse and HIV, financing, adolescents, and workplace issues. The Commission's final report, "AIDS: An Expanding Tragedy:" was released in June, 1993 (TAB C). The report calls for a strong emphasis on prevention as well as leadership at all levels articulating the issues to their constituencies and the development of a clear, well-articulated national strategic plan that addresses the issues of prevention, care and research.

The Surgeon General's Report to the American Public on HIV Infection and AIDS, released on June 10, 1993, provides factual information about the HIV/AIDS epidemic and means of prevention (TAB D).

DEPARTMENT OF HEALTH & HUMAN SERVICES Public Health Service

Office of the Assistant Secretary for Health
Washington DC 20201

JUN 24 1993

FROM: Acting Director, National AIDS Program Office

SUBJECT: Seventh United Nations Population Inquiry Among Governments

TO: Deputy Assistant Secretary for International and Refugee Health

This is in response to your memo of June 11, 1993, regarding information and background on HIV/AIDS in relation to international population issues. We are responding to Section 3, "Mortality", questions 308-314, of the questionnaire in a narrative format. Pertinent supporting documents are attached.

#308 - What is the viewpoint of the Government regarding acquired immune deficiency syndrome (AIDS) in the country?

Answer - #3 - Major concern.

#309 - Has the Government adopted special measures to prevent or reduce the occurrence of AIDS?

Answer - #2 - Yes.

#310 - Please specify the measures taken.

The Public Health Service Strategic Plan to Combat HIV & AIDS in the United States (TAB A) is the major document that outlines the agency's involvement in this epidemic. The purposes of the plan are to:

1. delineate the functional strategic efforts the PHS is undertaking to combat HIV and AIDS,

2. provide a framework in which each Agency can develop and implement a corresponding "tactical" plan which expands on this broader PHS plan, and,

3. disseminate to the public, State and local governments or other Federal departments, information about PHS' strategies and efforts to combat HIV and AIDS.

#311 - What is the experience of the Government with regard to the availability of resources needed to address AIDS?

Answer - #3. Major difficulties, substantial resources needed.

#312 - Please indicate the nature and extent of the difficulties encountered.

As HIV infection in the United States moves into its second decade, it is becoming clear that what was once thought of as a sexually transmitted disease among a limited segment of the population is now recognized as a multi-epidemic among all population groups. HIV infection in the U.S. is part of the rapid increase in tuberculosis, especially multi-drug resistant TB, sexually transmitted diseases, substance abuse, poverty, and homelessness.

The epidemic continues to expand, particularly among communities of color, women and adolescents. Due to longer survival after diagnosis, it is estimated that the number of people living with AIDS will increase from 90,000 in January, 1992 to 120,000 in January, 1995. Nearly half of all AIDS cases have occurred among African-Americans and Hispanics, although these two groups represent only 21 percent of the overall U.S. population. AIDS cases in women increased by 9 percent between 1991 and 1992 compared with 2.5 percent increase in men. Between 1991 and 1992, AIDS cases in adolescents 13 to 19 years of age increased by 65 percent.

As the U.S economy stagnates, fewer resources are available to meet the health care, psychological, social and housing needs of HIV infected persons and people living with AIDS. Since HIV/AIDS is primarily a disease of younger persons entering their peak earning years, the effect on the healthy workforce and the Nation's economy will be severe.

#313 - Has the Government placed restrictions on the entry into the country of people (immigrants, migrant workers, students, refugees and asylum-seekers, return migrants, tourists) infected with the AIDS virus?

Answer - #2 - Yes.

#314 - Please specify the measures taken.

The National Institutes of Health Reauthorization Bill was passed by the Senate and the House of Representatives and signed into law by the President on June 10, 1993. Section 2007 provided for the exclusion of aliens infected with the agent for acquired immune deficiency syndrome. This action amended Section 212(a)(1)(A)(i) of the Immigration and Nationality Act (8 U.S.C. 1182(a)(1)(A)(i) (TAB E). This exclusion applies to all visa applicants who are HIV positive or diagnosed as having acquired immune deficiency syndrome, regardless of visa application category.

Medical examinations, including serologic analysis, are required for immigrant visas. Applicants for tourist visas, however, are not routinely required to undergo examinations. All applicants are requested to fill out an application for the appropriate visa category and are questioned about their HIV status. All HIV positive applicants are ineligible for a U.S. visa.

The Attorney General may approve a waiver for an for the following HIV positive applicants. Immigrant applicants coming to the U.S. to join U.S. citizen or resident alien family members; applicants for refugee status; and non-immigrant visas for applicants attending a Department of Health and Human Services conference (10 day waiver); and applicants coming for personal business, medical care or family visits (30 days).

Thank you for the opportunity to comment on this interesting questionnaire. If you have further questions, please contact me on (202)620-4571.

Valerie P. Setlow

Valerie P. Setlow, Ph.D.

5 Attachments
TAB A - Strategic Plan to Combat HIV & AIDS in the United States
TAB B - Healthy People 2000
TAB C - National Commission on AIDS Final Report
TAB D - Surgeon General's Report on AIDS
TAB E - National Institutes of Health Revitalization Act of 1993 Conference Report

United States Department of State

Washington, D.C. 20520

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PS. Our mailing address:

Monika Naegeli
Dept of State / BRP
Rm 5824
2201 C St, NW
Washington, DC 20520

AIDS Action foundation

Return — can I make this?

September 22, 1993

Kristine Gebbie
National AIDS Policy Coordinator
Office of National AIDS Policy Coordination
Executive Office of the President
Washington, DC 20500

Dear Ms. Kris Gebbie:

On Thursday, September 30 AIDS Action Foundation will host its fall fundraising event "Jazz at Zei." I am writing to invite you to join us as our guest for this reception which takes place from 6:30 until 8:30 pm at Club Zei, 1415 Zei Alley, NW (located 1 block north of H street between 14th and 15th Streets).

You have been supportive of our efforts to advance a more compassionate and effective federal HIV/AIDS agenda and we want to take this opportunity to express our thanks. I hope your schedule will permit you to join us. Please RSVP to my assistant, Liz Kresse, at 202/986-1300 x22.

I look forward to seeing you on September 30.

Sincerely,

Hope you can join us.

Daniel T. Bross
Administrator

1875
Connecticut Ave NW
Suite 700
Washington DC
20009
Fax 202 986 1345
Tel 202 986 1300



Kristine Gebbie
National AIDS Policy Coordinator
Office of National AIDS Policy
Coordination
Executive Office of the President
Washington, DC 20500

1875 Connecticut Avenue, NW
Suite 700
Washington, DC 20009

PHOTOCOPY
PRESERVATION

Clinton Presidential Records
Digital Records Marker

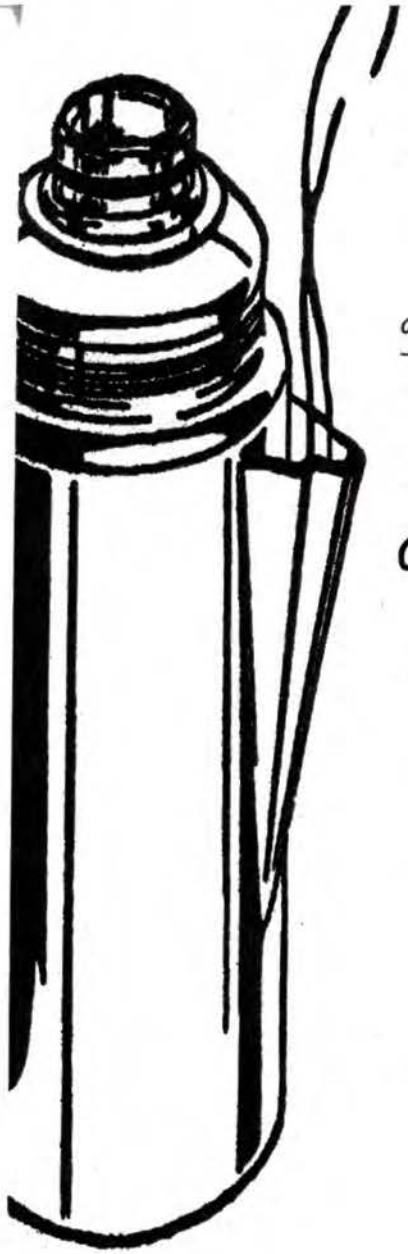
This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

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.

AIDS Action Foundation

2pgs



Timothy Boggs, Chair
Daniel T. Bross, Administrator
and the Host Committee
invite you to

an evening of

jazz *at* zei

Thursday, September 30, 1993
6:30 until 8:30 pm
Club Zei

Cocktails
Live Jazz
Hors d'oeuvre Buffet

1415 Zei Alley, NW
Washington

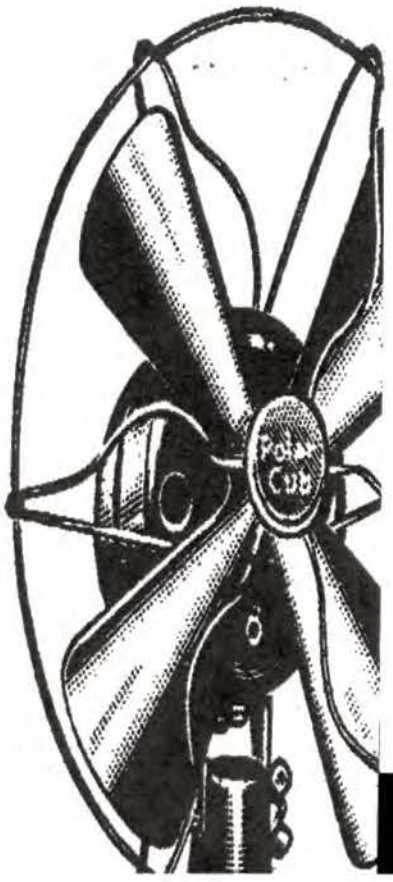
Zei Alley runs between 14th and 15th Streets, NW, 1/2 block north of H Street

AIDS Action Foundation

AIDS Action Foundation participates in the development of federal policy to ensure funding for effective research, treatment, prevention and care.

AIDS Action Foundation, a 501(c)(3), is a national public policy research organization. It works cooperatively with AIDS Action Council, which represents the interests of over 1,000 community based AIDS organizations and the individuals they serve.

AIDS Action provides national leadership to ensure communities receive the resources



AIDS TRAINING SESSION

Saturday, Oct. 23, 1993
St. Mark's Lutheran Church
1900 St. Paul St.
Baltimore, MD

sponsored by the
AIDS Task Force of the DE-MD Synod of the
Evangelical Lutheran Church in America

Morning

9:00-9:30	Registration and Refreshments.
9:30-10:00	Responsive Prayer 1 (Suffrages) in Chapel
10:00-12:30	AIDS 101 Panel. Baltimore City Health Dept. HERO American Red Cross
12:30-1:15 p.m.	Lunch

Afternoon

1:15-4:45	Integrating HIV/AIDS Knowledge and Prevention with the Spiritual: Caring for People with AIDS. AIDS Task Force Clergy Coordinators Joseph Richey Hospice AIRS/Don Miller House PWA Coalition
4:45-5:30	Responsive Prayer 2 (Suffrages) in Chapel

HERO	Health Education Research Organization
AIRS	AIDS Interfaith Residential Services
PWA	People With AIDS

Giving Blood Is Safe and Easy

- Your body quickly replaces the blood you give.
- It is safe and easy to donate blood. An hour is all it takes to give blood to save another's life—the actual donation time is less than ten minutes
- If you are aged 17 or over, you are eligible to donate blood. Some states require a parent's written consent if you are under 18. If you are aged 66 or over, you may be accepted as a donor, after your health history is evaluated at the blood collection site.
- The Red Cross collects blood only from **voluntary** donors.

A Cost-Recovery-Based Service

Red Cross regional blood services are financed by recovering expenses from the users of their services. The Red Cross charges hospitals a processing fee to cover the expenses of recruiting, collecting, testing, processing, and distributing blood and blood products. This fee is directly related to costs. Hospitals pass the charges on to the patient whose health insurance plan usually covers the expense. The blood itself is never charged for because it is a volunteer's free gift.

Stock No. 321197 (Rev. 5-84)

SOME FACTS ABOUT BLOOD

American Red Cross

The Blood in Your Body

- The average adult's body contains about 10 to 12 pints of blood.
- Your body continuously replaces its red cells, making new ones with iron salvaged from old ones that have been retired.
- Blood transports nutrients and defensive antibodies, cells, and clotting factors; red blood cells deliver or release oxygen.

A Single Donation Sustains More Than One Life

One donation can be separated into components and used to treat several patients. Some uses for blood components through transfusion therapy follow:

- Packed red cells are prescribed for anemic patients.
- Platelet concentrates control bleeding in leukemic patients.
- Plasma from many donors is pooled to make derivatives such as antihemophilic factor, albumin for the treatment of shock, and gamma globulin which may prevent or make less severe certain diseases.
- Cryoprecipitate is administered to patients with hemophilia A.

What's Your Blood Type? Find Out by Donating.

Blood groups are inherited. In our population the following percentages are found for ABO and Rh blood groups:

38.4 will have group O positive blood.
7.7 will have group O negative blood.
32.3 will have group A positive blood.
6.5 will have group A negative blood.
9.4 will have group B positive blood.
1.7 will have group B negative blood.
3.2 will have group AB positive blood.
0.7 will have group AB negative blood.

(The actual percentages of blood types may vary from one region to the next. These figures reflect the average of seven Red Cross blood services regions.)

PHOTOCOPY PRESERVATION