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Pat Hughes

THE WHITE HOUSE
WASHINGTON

2587

March 25, 1975

Alan H...

MEMORANDUM FOR: ROLAND ELLIOTT
FROM: STANLEY SCOTT
SUBJECT: Transcription of Tapes

[Handwritten initials]

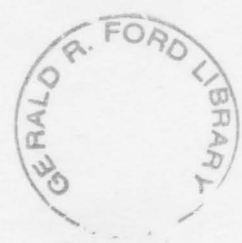
Roland, would appreciate it if the attached tapes could be transcribed and returned to Room 179, EOB.

The agenda of March 25 meeting is attached.

Thank you.

Attachments (3)

pers in Correspondence
3/28/75

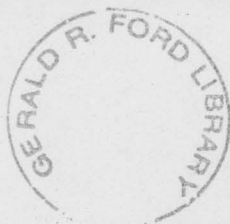


TUESDAY AT THE WHITE HOUSE

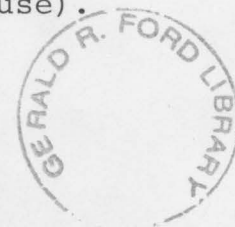
MARCH 25, 1975

A G E N D A

1:00 p. m.	Coffee	Family Theater
1:15 p. m.	Welcoming Remarks	Stanley S. Scott Special Assistant to the President
1:25 p. m.	Greetings	William J. Barody, Jr. Assistant to the President
1:35 p. m.	Introduction of Speakers	Stanley S. Scott
1:40 p. m.	Neighborhood Health Care	Dr. Theodore Cooper Acting Assistant Secretary for Health HEW
2:00 p. m.	Questions and Answers	
2:40 p. m.	Coffee Break & Photographs	
2:55 p. m.	Panel Discussion - Health Care Problems and Some Solutions	Secretary Caspar Weinberger HEW Dr. Theodore Cooper Acting Assistant Secretary for Health, HEW Dr. Robert van Hoek Acting Administrator Health Services Administration, HEW Dr. Paul Batalden Director, Bureau of Community Health Services, HEW Dr. Louis Hellman Assistant Director for Population Affairs, Office of Assistant Secretary for Health, HEW
3:15 p. m.	Questions and Answers	
3:45 p. m.	White House Tour	



Well for those of you who arrived late in the Family Theatre over in the East Wing, I'd just like to again -once again say welcome to the White House and welcome to Washington those of you who arrived from locations out of the city. I'd like to get things moving with an introduction for our Government officials who are with us today. To my left is Dr. Theodore Cooper, Acting Assistant Secretary for Health at HEW. Dr. Cooper - would you stand. (Applause) Dr. Paul Bathalden to the left of Dr. Cooper. Dr. Bathalden is Director, Bureau of Community Health Services (Applause). And to my right is Dr. Lewis Hellman, Deputy Assistant Secretary for Health. Dr. Hellman (applause). We had expected the Secretary of HEW to kick things off for us today but as is often the case here in Washington in Government Cap Weinberger was called to the Hill at the last minute. We do hope to have him with us before we adjourn this session. One other note, after we've completed our dialogue here/^{for}those of you who are able to remain with us will be moving back to the White House area - the immediate White House area for a guided tour - a special tour of the White House for those of you who are able to remain. We expect this session to end approximately 3:30 -3:40 as we do have another meeting in here with the Vice President at four o'clock. I said earlier we hope that this session if it does anything will provide us an input - as I said earlier as well we've got our recording equipment in here and we will be taking down all the input that you give us today and we hope that you look upon

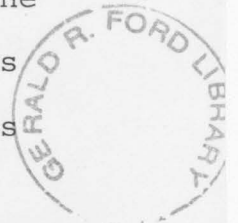


this session as a talking with session as opposed to a talking too session. Dr. Cooper will make a presentation and then if you have some questions of him you might want to go right ahead and ask you to involve all the panelists. They do not have any major presentations to my knowledge and we'll let Dr. Cooper kick it off and serve as a point man. Dr. Cooper.

DR. COOPER: Thank you Mr.Scott. Let me say ^{for}/~~to~~ the Secretary that he will make every effort - he as told me - to drop in and try to chat with us in between his appearances down on the Hill. We have told him of the change of room and we expect that will facilitate his schedule if the Congress turns him loose. The - we have also the Administrator of the Health Services Administration Dr. Van Hougk also on the Hill finishing testimony which we expected to have been finished yesterday who will also join us if and when the Congress finishes with him. I think they're all germaine hearings because as you are well aware these are the programs that Dr. Van Hougk is testifying on today that are directly relevant to the - your interests and the interests of our dialogue today. Now - I'd like to start off by reviewing just very briefly what you probably know better than I and that is the purpose of these programs in the community health field. They are principally concerned with reaching the under served populations, correcting inadequate distribution of health services, improving the quality of health care, foster effective and efficienty health service delivery and providing services



to statutorily defined populations. Now these main programs of interest to you we categorize under community health centers, the migrant health program and the family planning project. And our proposed budget for this which I know is very much on your mind is for 1976 is a total of 253,825,000 dollars. We count up a total of 157 community health centers which represent the combined total of 127 neighborhood health centers and 30 family health centers. And as I understand the difference between the two are some special experiments in pre-payment which identifies the family health centers. It's our estimate that you serve 1.4 million people and the main focus of your over-all care is in the area of what is known as ambulatory/^{health}services. And obviously these programs constitute an important community health resource for persons living in the medically under served areas in 41 states, the District of Columbia, Puerto Rico and the Virgin Islands. We have 105 migrant projects serving 355 sites in 37 ~~states~~ and jurisdictions and we are serving about 400,000 people in that program. I would distinguish in all of these programs the difference between numbers of people and patient encounters or numbers of visits which as you know is a very important distinction when we get down to our discussions of cost. The family planning projects are currently providing service to approximately 1.6 million persons who reside in 2,920 counties, that's 95% of the 3,074 counties in the United States, with a total proposed budget for these programs is of interest to you and concern



I know, and I would make at that point then some general ~~XXXXXX~~ comments about the health budget. We expect to propose to the Congress, the secretary has already made his initial presentation, I am planning to make the initial health presentation on April 7 to the appropriations committees in the Congress. The initial proposals here will recommend a budget authority of about 30.5 billion ^{dollars} in health from the Department. Now this represents an increase. Now I'm going to talk to you about some decreases. ^{But} the first fact I think we have to start from is that what we're proposing is an increase but a lesser rate of increase than has taken place in previous years. The largest part of that 30.5 billion dollars is allocated to Medicare and Medicaid and we expect that there will be about a 1.2 to 1.5 billion dollar increase in that portion of the budget. The remaining 6 health agencies with the grant and contract program including yours will account for somewhat below 5 billion dollars and in this particular segment of the budget the net recommendation is for decrease in the Federal participation in the program. There were about 8 general principles or issues that I think I should lay on the table as the general criterion which were followed in determining the budget allocation.

First was that the budget reflects the decision to require that the states and local governments, private institutions, and third party payers contribute a greater share of the cost of the health care programs than they're currently supporting. That decision affects virtually all the health services programs whether they be in the Health Services Administration or the

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Alcohol Drug Abuse and Mental Health Administration or some other CDC programs.

The second principle is that we expect the Federal funding for medical care of our direct Federal beneficiaries such as the Indians, the Alaskan natives, the Coast Guardsmen, the American Seamen, ~~XXXXXXXXXXXX~~ will be increased to maintain or improve the quality of their service. Now this increase is a very modest one. I'm talking here about 14 million dollars over a base of about 300.

The third principle is that those programs which are directed towards bringing about change or improvement in the Nation's health delivery system, structural changes like the PSRO program or the HMO program and so on will be maintained at about the same level. There is some increase in some of them proposed by the Administration trying to restore some cuts that were already applied to those programs in previous Congressional actions.

Fourth, we will continue to support preventive and regulatory programs of the Food and Drug Administration and the Center for Disease Control in order to keep our eye on the spread of disease and to assure the safety and quality of foods and drugs, water supplies and so on.

Fifth, there'll be a new federal policy governing support for a health manpower development and training of medical researchers that we have --. Our authority for programs in this area has expired. The Congress is debating that at the current time. Our proposal for that is a reduction in federal



share

share also.

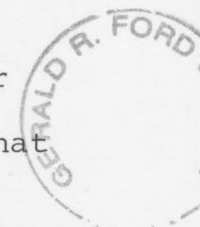
Sixth, we will continue support of bio-medical research, since the Congress has decided to reject the President's recommendations on recision for the '75 budget, we will be recommending an overall reduction in our research efforts for the coming year in order to bring that budget in line with the overall strategy of the President for 1975 and 1976.

Seventh, we will continue to honor our commitments in alcohol, drug abuse and mental health programs but we'll not propose any extention and the net effect will be a recommendation for a reduction in budget of the Adam Hoek programs.

And eighth, and importantly, we will be trying to implement rapidly the recently inacted National Health ~~AND~~ Planning and Resource Development Act of 1974 which the President signed on January 7. This will require additional funds and since the President did sign that bill we will be seeking a modest amount of funds within that authorization to implement that program. Now the total proposed budget as I mention emphasises increased cost sharing by non-Federal sources thus, while the 1976 level represents a reduction of approximately of 20% from the 75 level we hope, and that was the assumption that the President made in his final decisions about the budget, these were very difficult ones because they involve people programs was that we would be able to maintain our service to the same numbers of people or better if the objectives of increasing the non-federal sources was successful. And the proposed budget level plus this expected increase of the non-federal sources



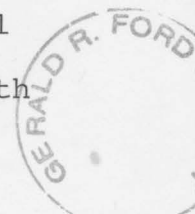
were designed to try to maintain that level of activity along with some management changes to help project efficiency. Grantees will be assisted in recovering third party reimbursements for services that are covered by state medicade plans, the medicare program or private health insurance and to facilitate this effort the Department will propose an amendment to the Social Security Act requiring that non-hospital affiliated health clinics be included in each state medicade plan. We hope that this is a help in achieving self-sufficiency. There are some legislative changes going on ^{which} ~~that~~ I would just touch on because as you are aware the authority for some of the programs that you are involved with also expired last June. The Health Services Act or the Health Revenue Sharing Act as it is sometimes called was passed by the 93rd Congress, was vetoed by the President at the end of the year. This bill is pending action in the Senate and in the House there are some differences which I would mention. S. 66 is a reintroduction of the Health Services Act. It's very similar if not identical to the Bill that was vetoed. It still contains new categorical programs, large increases in the authorization levels for funding and it was on this basis that you will recall that the President recommended the veto. There's an important feature that I would mention. Attached to this Bill is a amendment offered by Mr. Bartlett for himself and Mr. Helms and Mr. Buckley that would prevent any fund - not only



the funds for this program or departmental funds, or public health service funds but any Federal funds for being used in any manner to pay for or encourage abortion. Now this is different than the current situation. It's an important difference. The amendment may delay passage of the act where at least some time ^{while} ~~where~~ this is debated you can well understand the impact that this kind of an amendment would have. In the House there is a clean bill provided by Mr. Rogers its H.R. 2954. It's a reintroduction of the Health Services Act but with certain modifications. The authorization levels are less. Less of the categorical activities are in it. This bill has not yet been reported out of Committee and there are some other suggestions being entertained that when it does one would be that the Federal project grant and contract funds be at least 90 per cent of the total operating cost of the project except when this ratio is already less in on-going projects. This is important to you because it's obviously different from what the Administration proposal is. In on-going projects the Federal share could not be reduced below its present level by that Amendment and as I mentioned it is opposite to the Administration's proposals for funding for '76. It is also opposite to the Administration's proposals for legislative authorization in which we requested consolidation authorities for all three 14-E programs. The second Amendment in the Sub-Committee would assure that the public and private projects at the local level would be able to receive individual grants and contracts. This proposal if applied to



existing grants and contracts would reverse much of the grant consolidation efforts over the past few years and it's our belief that this would also cause some delay in the activities at the present time. So I wanted to highlight for you what was going on in the department and on the Hill about these programs. What are basic philosophy has been and the proposal for 1976. And I would make only one other comment and it will seem somewhat paradoxical I would admit. Throughout our rhetoric in the past several months we have been urging that we find ways to reduce hospital utilization as the primary source of medical care for the community. We want to get medical care for all the population and the proper balance for those areas which should have home health services as well as ambulatory services. And I think you might well have some questions about how these two objectives jive with the budget proposals we are making. Finally we are making attempts as you are aware with new guidelines from Dr. Bathalden office in particular on the operation and management of these programs. We think this will be a great benefit to you irrespective of what the eventual funding and authorization patterns are because I think we are concerned as the country moves toward a program of national health insurance and as you know the President has deferred the Administration's submission of a proposal 'til next January although he has indicated that this will be the time table on which the Administration proposal will be submitted since we all seem to be working toward that end we think it's important that structure

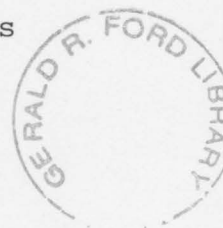


elements in the system such as yours be able to compete with other sectors of our pluralistic health system when the time comes to be able to retain and attract patients. So I think a great deal of the management features and the accountability features and the ^{guidelines} ~~guidelines~~ that are being developed for the service programs and the community are directed at that objective. Mr. Scott I think I will stop at this point and I would just comment that the man who just came in to my right is our Administrator of the Health Services Administration at the present time that's Dr. Robert Van Houck . All four of us would be pleased to respond to the questions or comments at this point.

SCOTT: All right. Let's start in the rear back there.

QUESTION; I'm a little concerned about the increase and reduction of federal spending and the increased matching or hope to match by state and local places. What my concern is where are they going to get the money from. The economy is bad and I would think this would be a time for increased spending -Federal spending rather than reduction.

COOPER: I think that is both a fair question and a not unexpected one. We - since the submission of the budget I think this question has been raised at every group by every group that we discussed the budget proposal with. Now in 1973 if you look at the trends of state and local government financing, we were optimistically impressed that they were on an upswing with the Health Revenue Sharing proposal we saw some light. The overall trend at that time '73-74 seemed to indicate that on balanced

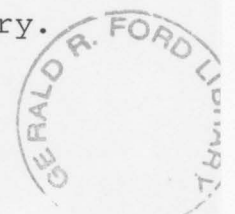


the state and local governments were going to operate in the black. But we recognize they have not been immune from the economic crises that the rest of the country has and I am aware that our current estimates is that they will be substantially in the red. And where we find ourselves is in a relative position. Who's more in the red. The local jurisdictions and states or the Federal government? Now when we prepared this budget the Federal deficit was estimated for '76 to run about 52 billion dollars. Since the the budget recessions were rejected generally that adds on another 17 since there have been changes in unemployment insurance required by the change in the employment status of the country large amounts of money have also been required and as you probably heard in the news from Secretary Simon recently and from the President himself and other spokesmen for the Government it is not unrealistic to expect that deficit to be 75 or 80 billion dollars. Now that's alarming. So it's not that we do not recognize that the states will have serious problems in trying to find some of this additional resources for new programs or new responsibilities the question is who can afford it more and what's more important. We have found in our program that we've had to realign some of our priorities. And perhaps the states and other programs will have to look at the same choices. Of course it's always a possibility that the Congress will not see the '76 proposals as we see it either.

QUESTION: We have a cross section of individuals represented



here from all phases of health care - hospital administrators, individuals from neighborhood health centers and we also have representatives from the communities that we serve that are concerned about the continuation of health services in these various communities. I'm quite sure they have say something they want to say about that. One of my concerns and I think this is a concern of all of the individuals who are here is that we agreed that at this time we are in an economic crises and we've got to use good common sense about this and we see that this Administration is concerned about the rise in unemployment and seemingly is in the process of trying to do something about this unemployment through appropriating funds to provide new jobs. I'm from Atlanta, Georgia and I know we have recently had some 5 million or more dollars to come into Atlanta to provide jobs. However, this money is coming thore to provide nonexistent jobs that we do not presently have jobs that we will have to make up jobs that we will have to put together in order to provide services to individuals in order to cut down on the unemployment. Now as we read the budget for 1975 and 1976 and see the cut that is proposed there in a country where there is an admitted health crises in a country where we have already admitted that health care is the right of an individual to have this and we do have neighborhood health centers, hospital outlets and other services throughout these United States who are in the process of trying to render the needed health services for the people all over this country. As we cut back on the budget in these various categories it's going to affect us two or three different ways.



Number one it's going to affect the services that we will be able to render to people and it's going to put a hardship on the hospitals because the hospitals in these various cities cannot assume carrying out the services that are now being rendered by neighborhood health centers. And number two it's going to affect jobs. Individuals who are now rendering legitimate services. Individuals who are doing a job will be cut out some five to ten thousand jobs will be cut back. Now my problem and maybe you can help me because I can't see it. I don't understand how we can appropriate funds to cut back on unemployment and at the same time cut back on needed services which will put five to ten thousand people out of jobs. Now here are jobs where people have been trained to render a service that you and I say is a needed service. A necessary service. We're going to cut back on these services, cut out these jobs and at the same time we're going to appropriate funds to provide non-existent jobs some of them will be paper jobs. Now I'd like for someone for give me an answer in plain old common sense as to how we can put ~~put~~ the two together.

SCOTT: Even though Dr. Cooper lead it off I would like for all the panelists to join in and we'd like for you to direct your questions to all the panelists and get everyone involved in this dialogue.



COOPER: Since it's on that kind of a policy question let me tackle that one for you Mr. Scott and see if we can get some resolution to that paradox. First off it is not the over-all proposal that we cut services. I know that your conclusion already taken was that if the Federal share is reduced it cannot be made up from any other source and therefore you automatically reduce services. But I think you have to listen carefully what the actual Presidential proposal was which was not to reduce the level of service but to try to maintain the total funding from different sources. The Federal share would be different. I acknowledge that it might be quite impossible under the current economic situation to achieve that goal but I think that the strategy by design was not to reduce the service level. I think that if we can hold that one factor on one side. Therefore the strategy to provide more jobs is not paradoxical from push pull mechanisms. The second point on the job provision which I think is important. We feel and I know the Secretary feels this way because he recently testified about health insurance for the unemployed on this regard. We feel that the best defense for health which is the final objective of all these programs is to have people at work because the health of the people suffers during unemployment, during economic recession from three factors. Not only from the loss of insurance or indeed the loss of services from specialized projects in communities such as your own but when unemployment goes up we do know that the health of the people tends to go down. But the things that go down



But the things that go down are usually things that are dependent on nutrition and that means making sure that money is in the hands of the people to buy food. Secondly, the kinds of diseases beside those of malnutrition, fetal death and the things that are related directly to nutrition are those items which result from people not having jobs. Alcoholism, automobile accidents, crime related injuries and so on. It's only after a lag of three to five years ^{do} ~~to~~ you begin to see an impact on several of the other disease categories. That means that the primary object would also be served by making more jobs. The third area is access to health services. And it is an important area. So my point is that basically it is not incompatible for the President to be suggesting at in the first level of economic crises that putting people to work is the best for them, the best for the humanity and indeed the best for their health.

QUESTION: I would like to introduce myself. My name is Curtis Allmond. I'm the Project Director at Temple University Comprehensive Health Service Program. I direct two neighborhood health centers and also represent the National Association of Neighborhood Health Centers as the President. I understand the answer that you just shared with Dr. Powell. However there are two other areas that concern me in terms of establishing priorities. The area of research and the area of planning. How in the world can we establish priorities in terms of generating enough money to continue research and planning and for you to share with us the fact that more money is put into those pots and yet there is not available money



to perform health services. How was that priority established?

COOPER: Again, I'll preempt my colleagues here because I have to bear the responsibility for that allocation. As I think I said I guess I didn't make it clear the research budget will be recommended for decrease. It will be. It will be recommended for decrease. Now in the original combined budgets of '75, '76 - '76 showed an increase of 36 million for cancer, 7 million for heart disease and 29 million for others. This was proposed on the suggestion that the Congress rescind in 1975 358 million dollars from the research program. That has been rejected by the Congress therefore we will be testifying on behalf of the President for a reduction of about 3 million or more in the research budget so I think we can bring that into line that we are not the over all strategy was to make every program participate in the constraints put on by the guidelines of the President. The planning activity is recommended for some money because three other agencies are being recommended for phase-out as you are probably aware. RNP, CHP and Hillburten and there's a new Health Planning Act. We will be seeking a supplemental as you are aware of 75 million dollars to get that program started in order to consolidate those programs. Our strategy here is not to try to make those dollars more than what has been previously been spent in those programs. It probably will show some increase because of the Congressional instruction to implement this program promptly and as you know



in that Bill it's a very tightly worded bill with specific deadlines in which we will be accountable to the Congress on those specific timetables.

QUESTION: My name is T. Roosevelt Butler and I'm the Administrator of Doggetts Hospital in Kansas City, Kansas. The question I have may not be proper at all but did I understand you sir to say that there is an amendment to the health program that will exclude any money for the payment of abortions.

COOPER: I think Dr. Hellman might want to comment on that and clarify what the status of that is - what the specific amendment is and I make it clear that it's not the Administration's proposal.

HELLMAN: There are two amendments. There's S. 318 and S 66 both proposed by Bartlett. They are both amendments to the Health Revenue Sharing Act - S. 86. They are both Amendments to S 66 and they both read approximately the same. I'll read the 86 one to you. Sec. 108 is amended to read as follows: "No funds authorized under this act or any other act may be used in any manner directly or indirectly to pay for or encourage the performance of abortion except in cases where such abortion is necessary to preserve the life of the mother."

Now 318 reads exactly the same except it applies only to Department of Health, Education and Welfare funds. This applies to all funds.

QUESTION: That I'm sure has been weighed against

HELLMAN: Yes. But we don't support -

QUESTION. You don't support - all right then.

QUESTION: Sir, two most important questions have been asked



of the panel and unfortunately I did not quite understand the answer to the questions. The questions were Why are we creating jobs for non-existing why are we cutting the services in the health field and creating jobs which are non-existent. That answer that the President feels it's parallel I don't think is sufficient. Number one. Number two we know for a fact - you take the case in New York for instance where the state right now has a 585 million dollar deficit, the city of New York this week must borrow 1 billion dollars if that banks don't hold them up that is, in order to make their payroll and you want them to put in a 20 per cent. Can you explain to me what is the thinking behind this because I really don't understand it in terms of economics.

COOPER:: Let me reiterate to make it simpler. The proposal of the Administration was not to reduce the level of service and put the people out of work. The assumption would be that the objective of the increased non-federal share would occur. Now your point is that in the second part of your question there is that New York State for example is having difficulty meeting their payroll and that the likelihood of New York State being able to assume an additional burden is unrealistic. I understand what you are saying. I explained in my initial comments what the situation was when that plan was made. The purpose of this dialogue as will be the purpose of the dialogue with the Congress will be to see where this falls out and perhaps as it's discussed some other solution will have to be found. Maybe 20 percent cannot be achieved. I think the point you make is well taken,

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QUESTION: Even though it's assumed that we do cut 20 per cent assuming that the Congress will abide by that and the Administration certainly would like that what happens to the 15 per cent of inflation that took place last year, the 15 percent that has taken place this year, the 15 per cent that has taken place this year which is two that's already 30. The 15 percent that we took which is 45 and certainly here in the neighborhood health centers I for one can attest to the fact that I had to let 30, 45 people go last week, because of the inflation. Now how do we deal with that. And on top of that how do we deal with the fact are assenters are increasing anywhere from 10 to 15 percent almost weekly because of the unemployment situation. How do we deal with the fact that that 10 or 15 per cent anywhere from 10 to 12 percent of those individuals do not have third party reimbursement and can only afford to pay ~~maybe~~ maybe three or five dollars from their unemployment insurance. How do you resolve these problems, sir with all due respects sir?

COOPER: With all due candor I can't. I wouldn't try to snow you for a minute. And I appreciate your comments. That's what I say I think as Mr. Scott says we're putting it on the record so that your concerns can be heard. I might say it's not the first time I've heard it but the - and I am not unsympathic to what the problem is you have to keep in mind however that if we take all our programs to the index of inflation what that Federal deficit would be and I think you find that you Federal 1 dollar and the stability of the republic would make for

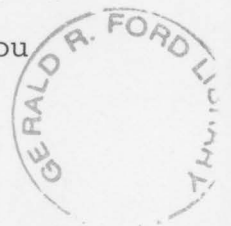


perhaps the neighborhood health center programs and others no more solvent from the standpoint that you're talking. Now I'm not an economist but I think that it is quite clear that we cannot pay all of our programs to the inflationary index. I do recognize that several of the other programs that have visited me personally have made clear to me the impact of inflation even at current stable budget levels if they had it, is on their employment. Most of them have reported to me and I was delighted to hear that despite that with the improvements that they've made since the inception of the programs in the mid 60's that they have not had to cut down services to the same percentage that they are still trying to provide the same level of coverage for these people. We don't have an easy answer for that question.

QUESTION: I've heard you say several times that the Administration anticipated no cut backs in the number of people to be served yet in the budget itself it indicates that in fiscal '76 the health programs would serve only 306,600 people down from almost 400,000 for the previous year. Would you explain that.

COOPER: In our analyses if it were totally dependant on that and didn't achieve it that would be the level that would have to be justified.

QUESTION Are you saying then that 67 per cent of the population that we deal with is not eligible for any kind of third party coverage where ~~why~~ was it anticipated that we would make up the difference?



COOPER: State and local jurisdictions.

SOMEONE: That's nonsense. (Laughter)

SCOTT: Said for the record (More laughter)

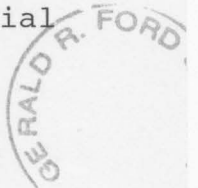
SOMEONE: That's nonsense.

QUESTION: -- of the Administrative Health Center in Oklahoma City and I would like to address a series of comments and questions to Dr. Bathalden and Dr. Van Hought and finally Dr. Cooper. Dr. Bathalden it's been my assumption after reading 42 CFR, Subpart 50 that the regulation for health services funding were in part designed for purpose of streamlining both fiscally and manangerially the topics of neighborhood center programs. Now my statement and question to you first is that true?

BATHALDEN: The Health Services funding regulations were to develop a clear relationship between forward financial planning and current center management.

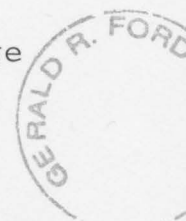
QUESTION: All right that being true then it must have been assumed that the effect of this regulation would be to have some sort of streamling effect financially or fiscally on the program and result in some capturing of funds due to cost saving by lowering - increasing the managerial potential of the health centers.

BATHALDEN: I think the evolution of that policy was one that eventually concluded that those monies that were being used in centers and were a part of the health services funding policy that those monies would be used to expand the number of people who were served and the emphasis was on expanding the service rather than on taking the funds away from either



the appropriation or the program. The emphasis was on expanding services and expanding the managerial capabilities of the centers to provide those services.

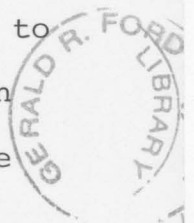
~~DR. VAN HOUGH:~~ ^{Somewhat} I maybe have the wrong department but I think in the administrative area ~~xxxx~~ may be dealing with the efficiency of such a regulation and back its implementation if its to become to work in terms of meeting the objectives of the Administration. Many, many objectives were set concerning proper health centers but the three basic ones that~~they~~ they would in fact reduce utilization of high cost hospital care. The report released by the Department of Community Health Services in fact in 1973-74 U.S. average was 1,160 hospital days per thousand and CHS' 762 for a 34 per cent decrease in terms of the higher cost of health care being delivered by the hospital. In terms of physician productivity. A light statistic - national average 2.8, CHS medium 2.1. Of course OMB came up - GAO came up with some statistic of 1.97. My theory is that they left something out. Cost of services-essential quality. Physicians offices approximately 13 dollars for a physician encounter at his office. But at CHS where we all know that several volumes of different services are delivered vis a vis all the support services physician and the supporting services only 24 dollars. (inaudible) being in business for over 30 years (inaudible) There is only a two dollar difference between a pre-paid practice that's been established for all this time and a in terms of a physician visit our value of service is



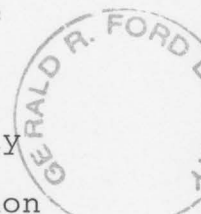
probably lower than a physician's office. Now in terms of over all statistics that means that the CHS medium in '73 was 167 dollars per capita for year. Gentlemen, I'd like to suggest that these indeices number 1 prove a point that CHS is a viable means of controlling your budget. In terms of cost allocation. If that's true than it becomes a- I think we would be remiss without making some sort of suggestion here. Number 1 being that the Administration before it drastically cuts out programs do a shifting (inaudible) terminology of responsibility for sharing they allow these regulations to work because if these regulations are put in and enforced vigorously and CH's are able to comply with them to save not 50 million dollars but almost a hundred million dollars which in essence would be money returned to the pot to share back either in a revenue sharing concept or through an expanded services program. So in terms of that I would like to have a response from Dr. Cooper in terms of your feeling about the analysis I just made in terms of the (inaudible).

COOPER: You initally addressed some comment to Dr. Van Hough and ^{he} maybe ~~you~~ could reply.

VAN HOUGH: Well, there's no question based on CHS data and other data as well the comprehensive ambulatory health services can be performed in an economic fashion competitve with other ways of delivering services and in fact can significantly reduce hospitalization and the total cost either to the individual or to society for the care of that individual. There's no question about that. And we're getting more and more data

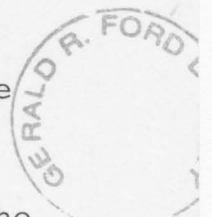


to substantiate that. It's also clear that from a number of studies that a comprehensive program in a well-organized setting can significantly increase the productivity of physicians by the use of paramedical personnel, and so forth and thereby hopefully in the long range help with man power, health man power and physician distribution problem to some extent. The question of the health services funding regulations is one in which we have to the present time through Dr. Bathalden's staff worked very intensely with the projects to try and prove the capabilities for developing better cost information. To develop eligibility and billing procedure so that maximum third party reimbursement can be achieved and the centers can use ~~xxxx~~ these funds to increase services to the area of population and presumably this would then lead to further reduction in hospitalization ~~xn~~ for that beneficiary group. We are however, as you well know better than we do as you're at the scene we still have the problems of other health ~~regulation~~ legislation being incompatible with that ~~of~~ objective. The services are not covered in many instances by third party paying programs including medicare and medicade and also the individuals state eligibility determination and certification of providers and so forth need to be resolved. I think we've made progress in that not to the extent that we wanted to and also we have in essence been forced into some delay in the further accomplishment because I think the data that we have developed with the centers and with other projects has led to a much more advanced look at terms of national



health insurance proposals. The fact that the National Health Insurance proposals do not model the medicare benefit package for some of the state medicade benefit packages or Blue Cross Blue Shield is an indication that some of this information is sinking in and that the many of the national health insurance proposals are - will cover when passed - would cover if passed a comprehensive program of services focused particularly on ambulatory care so that I think that both in the short term and the longer term we've made progress. Not as much as we'd like but I think we have made some progress.

BATHALDEN: I think one of the other things that is so frustrating for us and frustrating for you is ~~that~~ as Dr. Van Houch alluded to we have other laws that govern our operations. I think that the statutes of the medicade, medicare statutes that we have been trying to work with and garnering third party support and trying to effectively move the delivery of services and the support for the delivery of those services from a project grant support base to a stable more stable insurance type or third party payment type of financing is exactly the problem we face today where we have in essence the project grant supported activities on the "controlable" side of the budget and ~~the~~ the third parties the ones that continue to eat a greater percentage of the Federal health dollar on the so-called uncontrollable side of the Federal budget and it's that struggle that I think we are joining in the national health insurance initiative. We are joining in the national health insurance initiative. The data that we are gathering from our projects with respect to total health cost, with respect to



total health services is the data that in fact is being fed into the national health insurance formulation activity.

I'll stop there.

SOMEONE:

~~XXXXXX~~: Just let me say - I'd like to have your analysis because - I invite you to send it to me because I recently read a report where the average visit in the centers on several of the programs were not in the range of 25 dollars or 20-25 dollars. But were closer to 80 to 90 ~~dollars~~. And this might be including ^{part} of ~~your~~ social services a lot of other things in it besides medical services but I'd like to have - just quote for me from

BATHALDEN: You mean from the Comprehensive Health Services data based project report.

SOMEONE: Yes.

BATHALDEN: And it was a report on the management and program status of Community Health Services July 1974, *your office,*

SOMEONE: I think part of what I'm saying ^{is} that in that analysis not all of the programs involved as Dr. Van Hoke ^e said are included but in this particular project grant program those might be the ones that we need to work with. On the others, when they're lumped together, for other objectives, it comes out, at least in a recent report crossing my desk, a much higher number.

I'm JENNY L----- from ----- I think that we are all trying to say in one way or another that the Administration's position is either unrealistic and should be reexamined, or the Administration in a way knew exactly what it was doing but I think we really have to face this because the facts are fairly simple. What we are being asked to do is to cut back on the Federal support direct from the Federal Government and go to sources



such as other States and localities for funds when the very reason that it is a Federal program is because that source I've never seen ^{really to invest} very much ~~to invest~~ in the way of health services and preventive services. So we are being asked at a time of economic hardship to go to the least ----- of the possible sources of funds so I think this is realistic on that ground. The other sources which are fair party payment, are, even if they were maximized even if all the laws and regulations which would be _____ changed, would really not have that much possible yield very simply because most of the people who are on medicare are people who are on welfare.

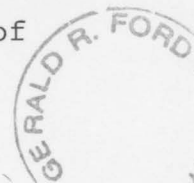
SOMEBODY: That's right.

JENNY L---- : And that there are many poor people who are not on welfare, they are the non---- working pool and families with husbands in the home. So that even if we did things right in terms of medicaid, it is still a low-yield source. When it comes to _____ care insurance programs, I mean private insurance programs usually provide very little coverage , and assuming that the population that we are caring for -----had insurance they probably would not have the kind of insurance that would cover preventive care. Lastly, patient fees, we find in some of our operation, ^{at this point patients} that people are defaulting on their bills simply because they are unemployed and they can't pay the bills. So, none of these sources are likely, and if they are not likely then the only thing that can happen is we cut back on programs.



I think we could keep saying, "No, no we are not going to cut back on programs" but we are going to do all these marvelous things I think we are deluding the American public and the Congress, cause they think everything is in hand, when it's not. I'd like you to comment on this.

_____ : Well, I think that is a very nice comprehensive analysis that I can take very little issue with it, except for the first part where you think we approach this by design. I think that -- I'd rather be ignorant, than stupid, you know, in that sense. To be candid with you, in our original projections of how we thought these things could be done, including beginning to get the system ready for National Health insurance, we were cognizant of all the points you made. And in our original proposals of how we could begin to get the system ready to be self-sufficient which is the objective, we did not take into account the financial crisis that is now upon us. As you're probably aware, our cycle of designing these budgets it goes about 18 months in front of ^{the} presentation of the end product. I would think that the decisions to lay on restraints and to seek even unattractive alternatives, is the result of seeking the fine ways which we could at least explore in a dialogue and maintain at least the forward thrust of some of the things we are trying to do. As it has been pointed out many times this afternoon, this and before, several settings, that this is probably, totally unrealistic from several of the standpoints unless we get to the point of saying we are willing to accept lesser levels of service. And that may be one point



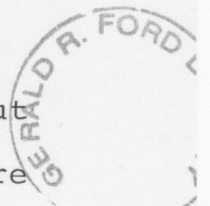
that we'll come to if that's the Nation's priorities, and as you know, from what is going on at the Hill right now, that dialogue is far from over, but I do think your comments were well taken. We were cognizant of them in our original design of self-sufficiency, and perhaps our strategy there ought to be re-looked at from the point of the fiscal situation at the time.

_____ : Gentlemen, I thought at one time that I'd been a woman whose taken some of these sentences that we have in discussion and not knowing so much about the sociology, and theology and all those little ^{kind} "ologies" that the _____ have been bringing to your attention. But, coming from a consumer's side of a person who have worked with the community health centers from the _____ section of health centers, who met here with Wilson long years ago in the 60's, who we were talking about trying to organize, and ~~which~~ to me which was a very beautiful job done. And as I stand here today, I get amazed and sometimes my heart takes two or three beats that millions of dollars that we have spent to try to educate people from the low economical communities ~~is~~ about the health condition of people in that communities. And highly important that the government wants you to have better health. And sometimes I read great big letters and notices, you know, about how beautiful it is, even in the schools, I would surely not talk about the beautiful part of what health means to us, and yet, yet, when we get that service, somebody up here with the confusion who always confuse the confuser, cause we already was

D. R. FORD

confused. So the confuser up here in Washington who confuse us who was already confused in the beginning. When black people, minority people, and I just don't have to say just chicanos and black people filipinos, and chinese and all the other low ethnic groups who had not been orientated of going to doctors. Some were alien, some were afraid, some were afraid that they had to see the assistanceship would be taken and that they would find that they was here, you know, illegal and some of the black people who had five dollars and their bodies were sick ~~and they~~ or something was wrong and they had 5 or 6 children, they suddenly would go buy some beans and bread before they would go to the doctor and ^{Dr} I feel we are going backwards and backwards and backwards. Then, our beautiful government came up with something, health communities, health centers in every city that comprise of so many people. And by gollys we thought that was the most beautiful thing that ever happened. We did more than that, if you could remember -- YOU, the government, furnished us money to train ^{our} the people and take them off st welfare so that they may be able to be the technicians and all the clerks and knowing how to talk about the doctor and all the miracle things that the patients were going to come in there, YOU did that! You allowed us that money to do that. And then you allowed us to be on the Boards and you gave us little stipends of 5 and 10 dollars a month when we made 25 and 30 dollars and gave them to the sinners and didn't even get paid for our gas and it was so bad, so bad,

t



that we had to _____ that we didn't have to go to
 _____ and remember now, I'm the chairman of the
 outpatient department at San Francisco General so I'm going to
 talk about San Francisco General where my people would go there
 in the morning at 8 o'clock in the morning and sometimes
 stay until 5 and 6 in the afternoon and still wouldn't get
 waited on. STILL WOULDN'T GET WAITED ON! But one day, YOU
 not me, cause I didn't have the power, to sign my name to
 no bill and I don't know anything about SBCD ED AND ANY ~~THE~~
 OTHER D's and don't give us that. But I do now that somewhere
 on top of this hill you provided service for my people and you
 gave us opportunity and I'm not getting emotional!

SCOTT : Let's not try to get emotional.

_____ : Let me tell you something you gave us that
 opportunity that we could stand proud and we could walk down
 the streets and have all the children _____ and feed correctly
 and then I heard this man say a few minutes ago that you wasn't
 going to pay for no more abortion. We don't care about abortion!

Danny I've got 19 grandchildren so you know we don't believe in the
 pills. But you did, your'e the one who said

SCOTT : Kindly keep your voice down, please.

_____ : I can't _____

You know this is from my heart and I must talk about it.

SCOTT : I know, we have quite a few people here and
 we want to give everyone a chance to

_____ : I'm going to be through, brother, I don't
 think my brothers today could be the ones who serves me. You know,
 poor people.



SCOTT _____ : Well, we certainly want you to have your say but-----

_____ : Let me get through, Mr., what's your name?

SCOTT: Stanley Scott

_____ : Mr. Scott, you know, that's my problem now. You know, every time we want to talk to the high officials that we are always shutup,-----

SCOTT: No, we don't want to shut you up, We don't want to shut you up.

_____ : But let me say this -- Gentlemens, if ever there was a time, that we need our health service, it is NOW. If ever there was a time that you cannot close the doors, it is NOW. I heard somebody say a few minutes ago that about 8% of the whole Nation was unemployed. By gollys, in the black and chicanos it always has been 8 and 15% that was unemployed. It always have been that. What I want to ----- upon you today is the millions of dollars that you have spent, the millions of dollars that you have erected these beautiful buildings and educated to go in there to serve the low and moderate income and I want to tell you one more thing, Mr. Scott -----

SCOTT: Right, would you please give us a question, No, I'm not nervous, I want to give everyone a chance to have his say.tho.

_____ : OK! I'm going to say one more thing. I am very full and I'm going to say this ----- I do hope that this Administration won't let this happen. To cut our facilities that we are so hurt for and I hope that the next time that I ever put my foot in Washington -- I hope that -- that I will be able to talk to somebody who has some sympathy toward the



problem that we are trying to talk about. ^{Today} And that you will have the time and the energy to listen and thank you, Mr. Scott for the little time that you have given me.

-----LOUD APPLAUSE-----

SCOTT: I would just like to add here a little footnote that we are appreciative of all the input that we received today and my only concern was that we have the chance for as many people as possible to have their say.

_____ : I have a speech that I'm going to give you and I ^{didn't} ~~am~~ going to read cause my heart's too heavy.

SCOTT: OK, I'll be more than happy to accept it. Yes, sir--

_____ : I'm Jeff Marilyn from the American Public Health Association. I think that you're dealing with a group here who is not naive enough to be frightened by such terms as inflation and deficit spending. I think we all know what the great economic experts in this country have led us into, and I'm not sure that the alternatives are so devastatingly terrible. I make a plea that we get away from those terms because they have two dangers. We're all familiar with the dangers of inflation and deficit spending. But I think the second danger involved is to use them as a smoke screen to justify certain actions. We're not talking here about multi-billion dollar increases. If all these programs we're discussing about the increases people here would want, the maximum increases we're probably not even talking about a billion dollars. So, the spectre of inflation and the spectre of deficit spending in the light of a 58 or 59 billion dollar deficit doesn't seem so great. We realize there are other agencies and there are



other people demanding programs. But these are people involved in the health field. And I think that they have a right to have what they need. We'll let the other people worry about their problems.. Now there is a certain illogic in what I've heard, and I'm sorry for that little introduction. The budget makes it very clear that it wants to control costs, and it talks very grandiosly throughout the budget about means of doing this. Yet, it makes it very clear that there is no intention of doing that because the programs that their costs are uncontrollable like medicare are going to show a 15.4 increase. Assuming that the budget figures are correct that the Administration.... Q: 15.4 what? (continues) A 15.4 increase in the total outlay as under Title XVIII in fiscal 1976. I'm sorry, 15.4 percent. On the other hand, as this gentleman here very eloquently stated, and I think other people could eloquently state for other programs, there are great potentials in saving great amounts of money -- maybe more than the 800 or 900 million dollars total increase we're talking about. The health center program, the family planning program, the HMO program, the PSRO program, all of these programs have either been decreased or have had small increases not commensurate with the needs of the program. And I think that in the sense of the Administration, you seem very penny-wise and pound-foolish in this way in not trying to develop those kinds of programs.



_____ :Okay, we'll go right ahead and let the secretary.....Go right ahead.

(Jeff Marilyn(?) continues)...What I was saying, I feel the justification to control costs, I mean, I don't think any of us is not enough bothered to believe that the funds are going to be absorbed for other programs. The budget makes that clear. For family planning, under Title 19, there is a 4 million dollar increase projected, while there is a 21 million dollar decrease in the funds available under Title 10 in family planning. And I think that kind of information could be applied to any program. We're not naive about that. We're talking about a decrease in services. We're talking about a decrease in services for those programs that are ^{labor}/intensive and would help the employment situation and that are means of either this year or in the future radically changing the delivery system and controlling costs. And I feel that to justify this on the basis of inflation or deficit spending is ridiculous, because what we're doing really by encouraging expenditures under medicare, by placing more reliance on Medicaid, which is really an uncontrolled program, were really then talking about deficit spending, then we're talking about inflation. They're not programs designed to do what I assume the budget intends to do.

MR. SCOTT: Thank you, Dr. Cooper would you want to respond to that?



DR. COOPER: Well, I think the point that is being made is one that we, that some of the ground we covered only from a little different vantage point. I was just briefing the secretary here on what has been discussed before and the speaker presently pretty much reviewed that. I think in his comments he raised the question of whether a relatively small amount of money in his terms that we're talking about to stabilize and expand these programs is the right priority that we selected to deal with the apportionment of federal moneys, and perhaps the man to my right is best qualified in the room to speak to the overall questions of national priority on this regard, because that's essentially the question we're asking, of where are we putting our priorities? And these programs are some of the other agency programs.

(Mr. Marilyn again, interrupts:) Well that's not right. I'm not trying to prioritize programs. I realize every individual has their interest, their program being a priority. I'm trying to say that we're all trying to control costs in the Health Programs, not prioritizing in comparison to labor programs, and other programs within HEW. They've got a place in those areas within the health area that are going to assure for the present and future costs are controlled.

DR. COOPER: I think the secretary will be delighted, I would expect to comment on his concerns of whether Medicare or Medicaid were properly structured to contain costs, in the same sense



that you are saying before. So that I think this is the general area that perhaps

_____ : Let's just take a second to welcome the Secretary for escaping the Hill and being here with us.

(Applause.)

The Secretary^{Wen Heger} : That's a nice hopeful introduction, but not quite true, because we never escape unscathed and I haven't really escaped at all. But I'm delighted to be here briefly and have an opportunity to talk with you about some of these extremely important problems. Not having heard, had the benefit of hearing, what you were talking about before, I can do what Robert Benchly used to do with examinations: He didn't like the questions, so he wrote things that he liked to write about. I will talk about some of the things that perhaps seem to me to be important, even if they may not tie directly to what you've been talking about. But I kind of think they will, from the very little bit that I have heard already. And the problem here on health care costs is a very severe one, there is no question about it. And I do feel that Medicare and Medicaid were improperly structured when they were adopted 10 years ago. I don't think there was a sufficient realization that injecting that amount of new demand with guarantee re-payment in virtually any amount the provider wished to submit, was going to be inflationary as it was. But obviously, it was inflationary, it had all the classic ingredients for inflation. And when you mixed with that the shortage as it was then of ^{health} care



providers in a number of situations, even at that time we didn't have anywhere near the surplus of hospital beds that we have now. With all of these things combining, you had a tremendously inflationary effect on health care costs, and we're still feeling the effects of that, and a matter of fact, I'm afraid we will for some time to come. And that's one of the reasons I have felt, though I don't like cost controls, wage or price controls, and I don't think ultimately they're very effective, but it's one of the reasons I think that in the health care field you pretty much have to go to that route. Because we don't have a free market in health care costs, we have the government that has injected itself now in one way or the other, rightly or wrongly, to a very considerable extent, and so I do think we have to have something that does contain costs in one way or the other. That is one of the reasons that our National Health Insurance Program contained a health care cost control, because that would complete the cycle and inject another additional demand into the system, not just for people of low income but for everybody, because everybody would be covered by the health care insurance plan. And so I do think that we do need to have some kind of restraints and perhaps, not surprisingly, I believe that the states and local governments are the best areas in which to administer these. Having seen and participated in attempts to control prices nationally and realizing that you can do that for a very short time, but not nearly as effectively as it can be done on the local level. So



I think you're cost control problem is a very real one, I think its essential that we do do something about it. We've been pleased that health care costs increases have slowed a bit, and are now about at the level at the cost of living index. But that's much too high too, so we don't really feel that we have in any sense finished with this problem, nor that its in any sense been solved. I think ultimately, not only for cost controls, but for a lot of the things I know you've been talking about, and in the neighborhood health centers and community family health centers, and in migrant health and things of that kind, that ultimately the answer to that is comprehensive national insurance. Not to the exclusion of a great many programs, but as a supplement to it. And I think that that would fill out the health care picture a great deal more effectively. The long-range answer, the one that I am convinced is the one that will do the greatest amount of good, and its one in which we have the very highest priority now, is the early periodic screening detection and treatment program for children of medicaid families and low-income families. That, I think, has the greatest potential for improving the public health of any of the programs in which we are working because it involves for the first time getting children of families that have not had any kind of exposure to medical examination or health care a rather full examination rather early, and the treatment. And we're up to about 3 million children now who we believe will be screened this year, we hope to reach 5 million next year. We



are perfectly willing to agree that we've been much too slow about this. The program was adopted in 1968 and it wasn't really until 2 years ago, 1973, when we started working on it actively, and it wasn't until last year that Congress gave us the ultimate weapon to withhold funds that may produce the kind of cooperation we have to have from the states. So I have great hopes for this program, and I think that that can do a tremendous amount of good, but I realize its very long-range and we have to do a great many things in the meantime.

DR. SMITH: Mr. Secretary, we're happy to know that you've arrived. We've been discussing a lot of issues today that really relate to the preservation of a system that we have, neighborhood health centers and all of the other/^{centers &}programs that are emanating therefrom. And I guess we're here to sort of ask the question whether or not you and the administration are indeed committed to the preservation of these systems. Some of the dialogue that we hear suggests that programming has gone on in order to make sure that we would be ready for the National Health Insurance when it comes along, that part of the program has been to deal with the issues of self-sufficiency etc., I guess our concern is that from what we hear relating to the budget cuts, etc., many of these centers may very well be killed off before national health insurance comes along, which everyone considers to be the panacea. We may not be here, and that's our concern. When we look at the fact that the health care portion of that total administrative budget is less than



10 per cent now; I thought it was roughly around 10.8 per cent, but Dr. Cooper tells me is about 30 billion dollars. I assume the President's budget is still at the range of 329.4 billion, and climbing, less than 4 per cent is for health services, for human services, really. Less than 10 per cent of that budget. That gives us great concern. Now when you speak of self-sufficiency of neighborhood health service, I would like to raise a question: How can you assume that we're going to survive, if indeed there is a proposal wherein the federal matching percentages to the states would be increased on a 60-40, rather than a 50-50 as it currently operates. If indeed we are relying upon those third party reimbursements from within the states from which we reside, either on a capitation/?basis or whatever, from the states and the moneys are not there, the states can't pump the money in to support the medicaid states' program, then we certainly cannot be reimbursed those funds. And if indeed we cannot enroll our patients, and many of these medicaid patients cannot be enrolled, we simply register them. And we have no control over that process in terms of dollars and cents. And if indeed as one lady has pointed out here the patients whom we serve do not have private health insurance, and the foundation's moneys are drying up all the time all over the place, from what source would we obtain third-party payment sources in order to survive? The federal dollars are being taken away and yet we're saying that we become more sufficient. We agree with that that we indeed would love to become more sufficient, efficient, etc.



Would love to carry the total ball ourselves. But how can it be accomplished? We don't see that. We would like to have your analysis and how it was programed that this really could take place?

SECRETARY WEINBERGER: Well, Dr. Smith, you've got an awful lot of points there, in that statement. And there are good points, valid points.

DR. SMITH:

SECRETARY WEINBERGER: Well, I'm delighted to hear it. Welcome to the club. It's a small group but we like it very much. We hope to make it larger. Those are very valid points, but let me say two or three things right at the outset. You asked if I was dedicated or committed to the maintenance of a particular institution. I am not dedicated to the maintenance of any kind of institution at all including the Department of Health, Education, and Welfare. I am dedicated to the maintenance of the service and the kinds of activities that are absolutely necessary and that should be done. But how they are delivered, I think is a matter of what's the best way to do it. I happen to think that neighborhood and family health centers is one of the very best ways to do it but I am not committed to the maintenance of any particular institution as such. I am strongly committed to the maintenance of the delivery of the services and I do think that neighborhood and family health centers are one of the best ways we have of delivering that. Secondly, you spoke about self-sufficiency



as if you may suffer from the same misunderstanding that some other people that I have talked to in Washington have suffered and that was the idea that by trying to move toward greater third-party contributions for all of these activities including many others besides neighborhood and family health centers there is some policy to rely completely on that and to require complete 100% self-sufficiency and that was never the answer. I had starting with a government institution, I called the clinical center at the National Institute of Health. I had the idea that we should, to the greatest extent that it is available, rely upon and draw any third-party contributions that might be there. I personally think that it is pretty silly to leave some money in insurance companies when people who have it available and could have it applied if any kind of reasonable activity were undertaken by people in various levels including the Federal government to get the benefit of that. Now if it isn't there, if the people, if an individual patient doesn't have insurance, if the insurance doesn't apply in that situation, why fair enough. If it does apply and it is there and the person's covered with it, why not lets try and get it. And that has been a point that I have had some difficulty in conveying because everytime I make it some people say well you are just going to close this institution if the insurance doesn't cover all of the cost and a lot of people don't have insurance. That's right, they don't have. But on the other hand, if you can get five, ten, fifteen, twenty percent, which we know we can, and



which otherwise would simple lie in the _____ of insurance company, why not get it. And so that's where all of that came from and I think that's essential. Now as far as national health insurance is concerned I think it will perhaps be a _____ I am getting a little skeptical of _____ in my old age but I think it will improve things substantially for a large number of people just as I think that this EPSTD Program will improve things for a large number of people. But I do think that we should use to the greatest extent that is possible and available third-party reimbursement and I think to the greatest extent that it is possible we should move toward a higher degree of self-sufficiency and it's in your own interest, because to the greatest extent that you can be free of outside sources or funding, and I know you can't be completely or maybe even fifty percent or any number but to the greatest extent that you can be it's infinitely better because you can make your own rules, you don't have to worry about regulations coming out of the department, you don't have to deal with other people, you can run and manage your own shop and that's a much better thing. Nobody is saying here, nobody believes here, that that can be accomplished 100% or the third-party reimbursement can run you, run all the funds or anything of that kind, but let's try and get the most that we can because the more you can get the better. Now one more



point and then we'll get a couple others. The point has been made frequently, very well by you and I am sure before I got here, to the effect that states can't afford a larger contribution rate and that Federal government will have to continue doing it or there will automatically be a reduction in funds and so on. And you've made the point about the percentage of the total budget going to these matters. Again, I don't think the numbers or the percentage is particularly important. If you do that you get into a lot of dangerous ground where you have to allow a certain percentage for each activity including Defense. Because all of our new friends and former enemies are allowing certain percentages of their budgets for defense so we should do it. I don't believe in that at all. I never did when I was here in this building running the budget. I think you ought to look at needs and try your best to get the amounts that match the needs and if it happens to be five percent, or if it happens to be twenty percent I don't care about that, but what I would like to do is get the maximum amount that we can to satisfy those needs. On the point about the States not being able to do so. That's a very interesting point. There is no doubt that any level of government and indeed a great many private activities, foundations as you correctly identified, are all having financial problems. In fact I can't think, looking back over some fifteen or twenty



years or I'm afraid more than that, in both the public and private sector in this sort of thing, I can't ever think of any organization or any activity that had enough or that could take care of all of its needs. There may be one or two but not very many organizations like that so everybody has got to select something. And my point on the States is that the States are relatively somewhat better off than the federal government on a proportionate basis though obviously they are not in fine shape and they do now have apparent deficits, though just last June they were in surplus to the extent of about two billion dollars whereas we've been in deficit for far too long. They are at least about as well off or a little better off on a proportionate basis than the federal government even though it may not be all that good. The point I'm making is that with the six billion that we are sending out for general revenue sharing and with the, the I've forgotten the exact amount now, but it's higher, I think it's fifty three billion, higher than it's ever been before for federal aid to state and local government. It is time for State and local governments to do some of the things we have had to do and that is make a selection and decide what are relative importance and I think neighborhood health centers, family health individual help is a very high priority and I think that we should ask the States to do some of the things



we're trying to do ourselves and that is to cut back and stop some of the things we are doing in order to assign more of the funds they have to these purposes. And so I think your efforts, quite properly are directed here but also ought to be directed to State and local government. To say you've got some money, you've got some new federal money, let's have some of that for our neighborhood health centers. So I think it's a matter of all having to try to contribute.

DR. SMITH: Yes, Mr. Secretary, I am impressed by actually the amount of agreement that we have all had this afternoon. We have heard that the administration was very upset at having to veto a bill that dealt in human services and we can _____ agree to that. We have heard you state that you feel neighborhood and family health centers are a very viable vehicle to deliver health services and we can certainly agree to that. We've, I think agree, prior to your coming in and perhaps to some extent since that twenty percent cut is no longer viable in view of the present economy as an across the board sort of thing especially in view of the fact that in 1973 GAO did a study and they proved in that study, I think beyond _____ that neighborhood health centers could never be under the present reimbursement systems more than twenty



percent _____ on a nationwide basis at best and that was in a very healthy economy.

SECRETARY WEINBERGER: Yes, but don't let me interrupt you, but just a quick point at that point. At that time a lot of the contributions from a lot of the centers a lot of the attempts to get third-party reimbursements were zero. And if they can go from zero to twenty percent I think we will agree that that's worth some effort.

DR. SMITH: And now that we have succeeded in going from zero to twenty percent can we maximize. And I don't believe that many neighborhood health centers one can maximize any more. I know that it is true in New York, I know that it is true in many California centers and I have a feeling it's true in most of the centers accross the country. We've already had enough TA and enough emphasis placed on self support so that we have maximized our third party reimbursement. And we are at the twenty, thirty, forty, fifty and sixty percent in some cases. And I know of one case where it's higher than that. We are at those levels, if we receive a twenty percent cut now there's nowhere to go. If we still have that room perhaps we would be able.

SECRETARY WEINBERGER: Now I think you are making the point that I was trying to and perhaps a little better than I was able to make it. You speak of this as a twenty percent cut and it is true that we are suggesting that there should be twenty percent less federal funding, but we are not thereby



saying that the activity is less important or that the amount shouldn't be the same or higher than it was last year. What we are saying is that the Federal government is this year less well able to make that kind of a continued contribution at that level than a combination of some other factors particularly State governments. And so everybody is saying why are you cutting the neighborhood health centers if you think they are so good and so on. We do think they are good, we do think they are very good. We don't look at it as cutting them. What we are saying is we aren't as well abled as some levels of government are to assist this particular year. Now I know there are a lot of hands up and each of you I'm sure are going to tell me that in your particular city things are horrible and I can't argue with that because you know about that than we do and that's exactly why I think there should be local control of these things, because you do know more about it. All we can look at is overall and also all we can look at is the problems that we have as a Federal government and they are massive and as you have seen are what we talked about was a 52 billion dollar deficit what is now getting very close to realization is a hundred billion dollar deficit and when you have it that high then you don't have just a lot of minus figures and a lot of people in the budget office worried, what you have is the necessary private capital to produce jobs is being dried up and diverted to non-job producing activity and that is



the worse thing that we can get into from a point of view of _____ or the national economy or anything else. So these are some of the considerations I think you have to have in mind to.

SPEAKER(?): Just to finish up, Mr. Secretary. I am impressed because from the time the conference started until you just quoted it, the projected deficit is about 25 billion dollars.

SECRETARY WEINBERGER: Well, nobody knows, you see I just came from the Hill, I'm very worried about letting them alone five minutes up there.

SPEAKER(?): Could we make the point that the states are in many cases _____ by legislation/ ^{to show a deficit} and in other cases they are actually in the process of bankruptcy and I don't think that they can with stand the 20 per cent. It's been agreed that we're anti-inflationary in the sense that we are probably one of the few services that cost less per visit today than it did per visit a couple of years ago. We are anti-recessionary in the sense that we employ people who were formally on welfare roles and who will be back on those welfare roles if we have to cut, and we have no choice.

SECRETARY WEINBERGER: You have know argument with me at all about the effectiveness or the necessity, what I'm arguing is that you don't have to assume that the states can't afford it because it might be a new or additional expenditure for them.



What I am saying is you should be just as persuasive with them as you are with us. That they should increase the priority they attach to this and perhaps go the unthinkable and diminish some other things in order to free/funds^{enough} for this purpose. That's what we are continually arguing with our own people about on high priority projects.

QUESTION: Can I simply ask is it possible in the way of compromise in the way of conciliation, the administration and Congress and we're caught in the middle, do you think it would be possible if the House bill which as was previously stated, has already been pared down quite a bit, from it's original, authorization level. If that bill were presented at an authorization level that is reasonable within the realm of survival for us, would it still than, if the Administration agrees, and if you agree, Mr. Secretary, would we still than have to look forward to a veto of that bill, of the authorization bill rather than the appropriations? The appropriations can be fought later when it probably will be a better battle. What we really need now is to authorize the legislation (authorization).

SECRETARY WEINBERGER: You've given me a very good out because you asked, made the assumption that the authorization level is reasonable and I've never turned down anything that's reasonable in my life. But I really don't know, I, it depends entirely of course on how the President views it at that time. And we do have to bear in mind that authorization levels tend to force appropriation levels. I strongly believe myself that

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we should get away from the difference between authorization and appropriation. In California when I was in the legislature and still I think we did very nicely by simply having a single level you appropriate funds as necessary and I think that's much better. I think an authorization level arouses a lot of expectations that frequently can't be met. But, I know the President shares the feeling that we have as to the importance and the necessity of this particular activity.

I know that he's worried about very high, unreasonably high, authorization level and, because of this fact that they can't be carried out or sustained, sometime by appropriations but I know that he would be very anxious to try to get a bill continuing this activity that is within what he thinks is economically possible for the government as a whole.

QUESTION: Mr. Secretary as a fellow Californian, I would like to just get back to California . The situation in Los Angeles with pre-paid health plans and that whole bit, to date there are about 2 or three community health centers that are now kind of getting into the pre-paid health situation. Prior to that there was something like maybe 13 or 14 private organizations that were in it for the profit _____.

I think based upon testimony that's come to Congress and the experience high cost of everything, I think that whole program is failed to an extent. But I'm interested in knowing is what the government is doing as far as mechanisms to make sure that once this money, the revenue sharing money or whatever money goes to the states that in fact organizations might



help so as they don't have a profit motive in mind .

What is the guarantee that some of that money will get there and probably get there before some of the centers close?

SECRETARY WEINBERGER: Well, as far as general revenue sharing funds are concerned, the idea there is that because people are closer to there state and local governments, they should be forced to come to Washington to make there pleas or to look for their protections of the kind you described which are entirely proper protections, but they should go to the state and local governments so generally the general revenue sharing funds would go to the state and local governments with the their ability to re-spend them very freely. And guided only by the general decisions of state and local government. With a few overall federal restrictions, for example, none of the general revenue sharing funds of course can be used in any way to [End of tape 1.]

Overall federal restrictions for example, none of the general revenue sharing funds can be use in anyway to violate any civil rights laws. It's one of the very few restrictions on general revenue sharing funds. Within that kind of protection than generally the revenue sharing funds go to state and local governments to spend as they saw fit. Controlled, I hope by



public opinion and people close to those governments so in your question you would not have to come to Washington. You would go to Sacramento or to Los Angeles to try to get better rules for the distribution of those funds to neighborhood health centers that are truly non-profit. And I know that non-profit in quotes organizations and you described a couple of them and I understand there very real problems with those. Aren't really non-profit at all. Because when you add in the salaries and the expenses and all they get to be pretty profitable ventures for some people. But I don't see any reason why the state and local government cannot require that in the funds that we give them in general revenue or their own that they distribute these to neighborhood health centers and let the neighborhood health centers establish their own pre-paid health care systems which I think in many cases, would be far better managed and do a better job.

The purpose of general revenue sharing is to eliminate the need to come to Washington to argue these matters , it's to be able to go closer to your home and get the decisions made there. That's the whole theory of it.

QUESTION: (NY CITY) Mr. Secretary, I have looked back as we all do in programs that are in the past, but I would like to take a look at the future and to hear what you have to say with reference to the impending national health legislation although the time table would suggest it won't come until next January.



SECRETARY WEINBERGER: Right.

QUESTION: I would certainly recognize the need for continuing programs such as the ones represented by the people here by whatever means possible because they do represent some major steps forward. But I would also like to look into the future, try to make sure we don't make some of the mistakes that have been made particularly when we make very significant concessions to rather strong lobbying interests, rather strong vested interests who sing the siren song and who insist that the legislation contain such phrases as without disturbing the traditional methods of medical practice and other such restricted phrases that prevent us from really picking the _____ sources that we have and distributing them in such a fashion that instead of being concerned with us as providers, physicians, administrators and what have you, that we would be concerned with what ultimately gets to every patient so that when the national legislation come about we will have a basic form that is without faults, that is for real, that has the patient concerns and that has the consideration for those who are least able to afford. These are things that are perhaps not always a part when we look at it from a budgetary point of view, although some of the finest people I know of are budgeteers, Mr. Beam and Mr. _____ happen to have a very strong budgeter influence on their program, but I do want to make sure that the programs that are designed



are programs that can have the ultimate effect that will translate the rhetoric of health care as a right into reality.

SECRETARY WEINBERGER: Those are very, very good points, Dr. Holoman, I have a great deal of trouble arguing with any of them. Let me tell what I see as some of the necessities for national health insurance. And I don't think the President's decision not to sponsor, to sponsor no new spending programs this year anyway is going to slow that down because I think that for one thing, the Ways and Means Committee to speak very practically indicated they can't begin hearings on the subject until October and our bill is all finished and is had hearings and put that in in January I don't think any time is going to be lost I'd like to see national health insurance take the form of a provision of health services and health providers on the freest kind of choice bases for people without regard to their financial resources and with only regard to their needs and I want to see that done because I have great prejudices on this subject and you should know that ahead of time I want to see this done without the federal government trying to administer or deliver it because my experience while we worked very hard and continue to work very hard to make the federal government as responsive and as effective as we can, I just think in the nature of the beast it is done much better if it is done without that kind of governmental operation and control and direction so what I would like to see/essentially contained in the Administration health insurance bill is a bill in which for people who are employed they joined together in getting, in

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paying the premiums for the kind of policy described by the government which is very complete, very comprehensive, and which covers all physicians visits, hospital visits, out-patient care, prescription drugs, alcoholism, mental illness, things that are frequently not covered and which under which people of lower income would have government subsidy for their premium down to the point they would all be taken care of. And the Medicare Program would continue but would have these benefits extended so that everyone would have the same access to comprehensive health care delivery. The things that I think in that bill that are important from the points of view that you mentioned are two: one is that there is a very high degree of flexibility with respect to the form in which the health services called for by that insurance would be delivered, in other words an employee could say I don't want you to help me pay insurance premiums, I want you to pay my dues or help pay my dues in an HMO , of my own choosing. And that flexibility is there. The other thing that is there is the fact that the government is not running it or going to deliver it or going to be paying all the providers directly or anything of the kind, and therefore you don't have to have that full scale governmental substitution of all of the very elements in the community that are now delivering health service, thirdly, as I mentioned a moment ago, there are substantial cost controls and that which I think are essential,



so that given all of this, given the fact that it is based on a sliding scale that, if your income is such, that you can afford it , than we'll always argue I suppose as to what that level is, you and your employer or you and your employee would share the cost. As your income fell or you didn't have any, then the government would pick that up so that you would have this kind of insurance coverage, you would be able to go where you wanted for your health care, if you wanted to go to a neighborhood health center/^{your}reimbursement there would come through these policies and so that you would have I think the maximum degree of coverage, the maximum degree of flexibility, and the minimum degree of government control and direction. That's the kind of health care program that I would like to see. With that kind of a flexible framework anyone of a/^{number}variations could be developed for the actual delivery and if you wanted a pre-paid system run by a neighborhood health center it would be qualified, if you wanted a HMO organization or run by a group of neighbors or by the health center itself that could qualify. This allows a degree of flexibility. The way I would not want to go would be to add 4 or 5 per cent to the payroll tax have the government sponsor the whole thing, pay for the whole thing, it would (quote) all be free (close quote) we would have a horrendous additional of governmental involvement and there are the rule books that tell you and everybody else how to practice medicine would be so thick that we would probably would not even



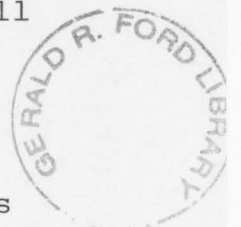
get them delivered and this is the kind of thing I don't want and on the other hand it's the kind of thing I've described I think would be the best kind of improvement and allow for the change of direction of delivery of health services anyway that seemed best to individual people to want to move it. That's the kind of framework I would like to see us establish. I hope it can be done next year.

SPEAKER: The Secretary had told me he had to get out at 3:30, I think it's about 3:40. Mr. Secretary do you have a chance for one more?

QUESTION: Mr. Secretary, I'm Dr. Harvey Webb, Vice President of the National Dental Association and Director of the _____ Health Center in Baltimore. I would like to give a slight analogy and ask the feasibility question. I don't totally agree with the approach that's been taken here, I think we've taken too much of a negative approach. We've been talking about cuts and so forth but let me give this analogy. Mr. Kissinger and we assume you'd like to give him credit for the effort he has made, has not been able to pull off the arrangement in the Middle East has he had liked.

WEINBERGER: Not yet, but we're hoping.

QUESTION: With the death of the King of Saudia Arabia this morning also made the stock market quiver or gain since yesterday. The collapse of the government in Southeast Asia has caused considerable concern and the economy here of the ~~national~~ ~~companies~~ ~~national~~ ~~companies~~ national companies ~~national~~ ~~companies~~ ~~national~~ ~~companies~~ /A & P cutting out a third of its stores and the metro utilities on the border of somekind of bankrupty make



the stake as I understand Mr. Kissinger is suggesting that we re-evaluate the entire situation and take a different perspective I would like for us to consider and to get your reaction sir to the possibility of regardless of what has been put in the budget , regardless of the prejudices that we have and regardless of the biasises that exist in the various aspects of our economy to re-look at the whole health situation and in light of the health crises, in light of the national crises the job crises to re-evaluate and tell me what the feasibility would be if we looked at it from that perspective of adding a 200 billion dollars to the health budget in the categories that have been considered for reduction and add that to the budget and revitalize this very important aspect of our own economy to promote jobs, to promote the elimination of persons going back on his own terms, to promote more self- sufficiency. What is the feasibility of that.

WEINBERGER: Quite a lot depends on whether you said 200 billion or 200 million.

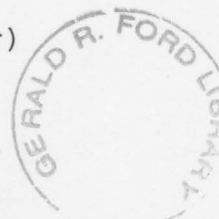
QUESTION: I said 200 million.

WEINBERGER: 200 million. It's an indication of how we are oriented down here that everybody up here heard you to say 200 billion but I'm sure that you meant 200 million.

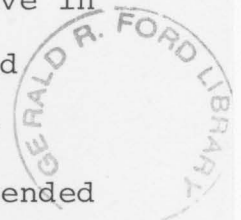
SCOTT: Mr. Secretary let me play the tape back. (Laughter)

WEINBERGER: God, you're not keeping a tape are you Stan.

(Laughter) Well, let me just say this it's a very general statement and that is so far as I am concerned and I'm sure so far as the President and everybody else in the Administration is concerned we would never feel that we had been so right



at any one time or so far from being wrong that we wouldn't be willing to re-evaluate anything, anytime. The difficulties with what you suggest are apparent because we do have what we felt to be an overall economic fiscal point of view a 52 billion dollar deficit's a pretty difficult thing for us old elephants to have to swallow and when you finally agree that that is probably the maximum amount of stimulation that can be possibly stood in order to get the economy rolling and all the rest and then when you see that not standing at all is any kind of landmark but being exceeded almost every hour and worrying as you do about whether or not you're going to have any capital left to invest in job producing ^{activity} ~~activities~~ which is the only way in which we're ever going to pull out of any of these problems. Then the addition of 200 million ^{comparitively} though it might seem ~~comparitively~~ small necessarily involves consideration of where are you going to get it, whose 200 million is going to come out to get this. In and of itself a quarter of a billion dollars against the total size of the Federal budget may not seem like very much but as I'm sure you know you are not the only group that wants an extra 200 million. There are a great many other groups and when I dealt with the budget and before I went into the Department I saw all of them every day. No body comes who doesn't have in mind some additions. Now this isn't to say that these kind of changes can't be made or that they might not be made by the Congress and accepted or that they might not be recommended by the President and we certainly are not above and should never be above the idea of reexamining all that we've done



and seeing if we can rise to meet ~~change~~ ^{changed} conditions and all the rest and obviously a lot of conditions have changed even in the couple of months since the budget went up. But I don't think anyone should have their expectations improperly aroused by my telling you that of course we're going to do that or certainly we will accept anything that's voted or anything of the kind. I don't know. Because large as it is I only have one department and there are a tremendous number of other considerations over-all fiscal problems rapidly changing conditions, inflation, all these other things that people have to keep worrying about but I can certainly assure you that the problems that are covered by this meeting today are considered to be and properly so a very high prime importance. We assigned a not inconsiderable resources to them. I know that in every activity a great many of the people concerned with that activity always feel that there should be more and I know that certainly there would be useful way to dispose of the additional amount you mentioned. Whether it can be made available or not I don't know but we certainly will and expect and do continually re-examine the situation and make additional suggestions to the President and he himself on his trips around the country is getting some very valuable input and frequently coming back with ideas or changes he wants to make. So to that extent we're flexible. The situation doesn't allow for very much over-all flexibility because we are at a point frankly where with the actions of the Congress and the apparently lack of concern as to this need to get some capital into job producing activities and worry about

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where you're going to get it when you have such enormous additions to the public debt to finance which is not job producing activity those have to be very real worries.

They may not seem as immediate but they're very real. But the brief answer to your question is yes, of course we re-examine all of these things all the time and certainly are perfectly flexible and willing to recommend changes anytime we think we possibly can.

QUESTION: Would you be willing to suggest that to the Presiden -

WEINBERGER: Well, I would be not - don't let me get into any situation where I'm arousing expectations. I know that we in our department do and I know the President does frequently and on a regular basis re-look all of these things. And we have to do it on the basis of changes that the Congress makes or in changes in individuals conditions that occur. Bear in mind that we've had just since the budget went up a very strong request that something like two and a half billion dollars not your modest 200 million but two and a half billion dollars be suddenly applied not that it wasn't budgeted, it wasn't planned be suddenly applied for a very limited purpose, health insurance for the unemployed. And supposing and there's a lot of support for that - supposing we accommodate that. Then what happens? Well that's two and a half billion and that's the way it has been going. So certainly we're going to re-examine all of these things but I can't in any honesty tell you that yes I'll go recommend that this be done. But I will recommend indeed I don't have to that we continually re-look and see what change conditions require.

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SCOTT: Thank you Mr. Secretary. (Applause) We're running just about on time. I understand the tour guides have arrived to take us over to the White House to get a tour. On behalf of the panelists I'd like to thank you for attending this session for participating in this session. I personally feel that it was quite meaningful in that we have begun to open a dialogue. I think that's crucial at this time that we began to communicate with each other. I look forward to hearing from you in terms of follow-up. My office remains open 24 hours a day to be of whatever services possible to provide to you. I know the panelists I would think that they feel the same way and in terms of additional input you know their names now you know where they are so you've got the name plates here and we're all servants of yours so look at it that way and let's try to maintain and strengthen this partnership in progress. We don't have everything we need in any given area of life today but I think by working together we can achieve some common results and in that light with that spirit thank you very kindly and let's move out now for the tour.

