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April 2, 1997

Mr. John Price
Office of Rural Health and Resource Development
North Carolina Department of Human Resources
311 Ashe Avenue
Raleigh, NC 27606

Dear Mr. Price:

At the request of Associate Dean William Small, I am responding to your letter of March 18, 1997 regarding the $500 contribution toward the expenses for the 19th Annual Minority Health Conference conducted February 13-14 in Chapel Hill. These funds were used in support of brochure printing for this conference. I have enclosed a copy of the brochure, which lists your office as a cosponsor, for the files.

The conference was indeed a success and we look forward to joint sponsorship of future conferences. If you need anything further, please do not hesitate to contact me. I can be reached by telephone at 966-6266 or my e-mail address is judy_beaver@unc.edu.

Sincerely,

Judy C. Beaver

Judy C. Beaver
Business Manager

:jcb

xc: William T. Small

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HEALTH POLICY REPORT

MANAGED CARE AND MENTAL HEALTH

JOHN K. IGLEHART

IN less than a decade, the treatment of mental disorders and substance abuse has undergone a dramatic change with the emergence of for-profit companies that provide managed "behavioral health care." To the angry dismay of many psychiatrists and other mental health professionals, decisions that were once largely their province must now be made in tandem with these commercial companies, with whom providers contract. Thus, like other physicians who have confronted the new imperatives of managed care,[1,2] providers of mental health and substance-abuse services (behavioral health care) are no longer simply advocates for the patient; they must satisfy multiple masters — payers, insurance-plan managers, and other consumers. In this report, I discuss the new connections between mental health services and managed care that have evolved because the companies contracting to provide behavioral health care have responded successfully to the demands of private payers for tighter cost controls and less expensive alternatives to hospitalization. State and local governments are also moving rapidly to contract with these same companies to manage mental health and substance-abuse services covered by Medicaid, one of the major public programs funding services of this type.

The coverage of mental health and substance-abuse services as a private insurance benefit has always fallen short of coverage for other illnesses. The nature of mental illness — its less well defined boundaries and the greater uncertainty of clinical diagnosis and treatment — has left most payers unwilling to provide unlimited coverage. Traditionally, private insurance coverage has favored inpatient hospitalization, a fact that has "frequently caused treatment decisions to be unduly influenced by the financial rather than the clinical needs of patients and providers."[3]

During the 1993–1994 debate on national health care reform, a new perspective on mental health policy emerged, largely because of the efforts of advocates within the Clinton administration.[4] Instead of focusing on strict limits on inpatient hospital days and outpatient therapy visits, the new approach emphasized the need to offer more comprehensive services, to shift behavioral health services into the mainstream of health care, and to integrate the private and public sectors.[5] In the end, of course, the national reform effort died. However, the three congressional committees that reported out legislation approved bills that incorporated mental health benefits into the basic health care plan, although substantial differences over the estimated cost were never resolved.[6]

With the demise of comprehensive federal reform, the national health policy scene shifted dramatically. The Republicans assumed control of Congress and pledged to erase the government's vast budget deficit by 2002. They are seeking spending reductions of $270 billion in Medicare and about $170 billion in Medicaid over the next seven years, as well as substantial reductions in a wide variety of federal health care grant programs. This thrust, if successful, will appreciably reduce the current level of federal spending for mental health and substance-abuse services, rather than expand coverage, as envisioned by Clinton's health care reformers. In addition, Republicans are pushing the expansion of managed care as a central tenet of their cost-control initiative.

Americans spent an estimated $85.1 billion for the direct costs of treatment for behavioral health disorders in 1990 — approximately 10 percent of all personal health expenditures.[7] But this average masks large differences among population groups and in sources of funding. In the aggregate, private insurance and out-of-pocket payments account for about 40 percent of all expenditures for mental health and substance-abuse services. The federal government, through Medicare, Medicaid, the Department of Veterans Affairs, and other programs, currently accounts for about 22 percent of total expenditures, and spending by state and local governments accounts for the remaining 38 percent.

THE ROLE OF MANAGED CARE

Whether applied to mental or physical health, all forms of managed care represent attempts to limit the use of services. The core techniques include authorizing only approved providers under contract with the managed-care company to treat enrolled clients, reviewing their decisions as they provide services, and monitoring high-cost cases closely. The empirical basis for expecting that these techniques will lower the costs of mental health care comes from studies that indicate that without managed care there is a great deal of unnecessary hospitalization,[8] that there is wide variation in patterns of treatment for various types of psychiatric problems, that lengths of stay can be reduced without influencing outcomes negatively, that cost-effective alternatives to hospitalization exist, and that a small proportion of enrollees account for a high proportion of outpatient visits.[9]

Managed care, when it is applied to behavioral health services, takes several forms. Health maintenance organizations, preferred-provider organizations, and point-of-service plans, the major variants of managed care, generally provide some coverage for mental health care within their broader benefit packages, but that coverage emphasizes acute care and, in general, is quite restrictive. Most managed-care plans do not cover chronic mental illness in their standard benefit packages. A typical benefit consists of a maximum of 20 outpatient visits and 30 hospital days a year. The services available within most managed-care plans are seen by mental health professionals as too limited for people with severe and persistent mental illness.[10]

Many health maintenance organizations contract with specialized companies that provide managed behavioral health care, in part because they lack the in-house capacity to provide treatment. These specialized com-

panies emerged in the mid-to-late 1980s, during a period of explosive growth of private, for-profit psychiatric hospitals. The contracts with these companies are controversial because the amount of money that health maintenance organizations generally allocate for behavioral health services (3 to 5 percent on average, whereas nationally such services account for about 10 percent of total costs)[11] is deemed insufficient.

Companies providing managed behavioral health care were to some extent a reaction to the private psychiatric hospitals. Many of the beds in private psychiatric hospitals were filled, as the current president of the American Psychiatric Association, Dr. Mary Jane England, wrote recently, "through sophisticated marketing campaigns targeting adolescents and substance abusers, resulting in many unjustified and even harmful hospitalizations as well as sharply increased costs."[12] Reflecting this trend, spending by employers for mental health and substance-abuse services increased by an average of 50 percent between 1986 and 1990. The most generous benefit plans were the ones that experienced the most dramatic cost increases. Saul Feldman, a former executive of the federal Community Mental Health Center program who now runs one of these companies (U.S. Behavioral Health), wrote recently that

> the greatest contributors to the development of managed mental health, a development they now bemoan, have been the service providers themselves, [fee-for-service] practitioners and facilities. By not paying sufficient attention to or not caring about costs and length of treatment, they killed or at least seriously wounded the goose that laid the golden egg.[3]

Operating Techniques

Without owning health care facilities or, for the most part, employing providers, the companies providing managed behavioral health care have brought about a dramatic shift in patterns of use. Using case managers and reviewers — most of whom are psychiatric nurses, social workers, and psychologists — these companies oversee and authorize the use of mental health and substance-abuse services. The case reviewers, using clinical protocols to guide them, assign patients to the least expensive appropriate treatment, emphasizing outpatient alternatives over inpatient care. Through toll-free telephone lines that are staffed 24 hours a day, seven days a week, they take calls from patients in search of help and from providers seeking authorization for treatment. These companies use a variety of techniques and processes. Some companies do not use clinicians as their case reviewers or do not share the contents of their proprietary protocols with practitioners.

Working with computerized data bases, a reviewer will discuss a patient's particular problem, then usually authorize an appointment with an appropriate provider in the company's selective network. On average, psychiatrists make up about 20 percent of any given provider network, psychologists constitute 40 percent, and psychiatric social workers make up another 40 percent. Although the nature of contracts with providers varies widely, most practitioners are paid a discounted fee. Current trends seem to favor placing providers at some degree of financial risk.[13] Thus, their remuneration is often directly linked with how strictly they control the use of services.

Of an estimated 185.7 million people with private insurance in 1994, 106.6 million were enrolled in plans that offered some type of program for managed behavioral health care. To determine enrollment, Open Minds, a private company that tracks industry trends, surveyed 40 of the largest employee-assistance companies and companies that provide managed behavioral health care, all of which operate for profit.[14] As of January 1, 1995, these companies had a total annual estimated revenue of $2.1 billion, with more than half ($1.3 billion) generated through contracts in which the firms are placed at financial risk for their performance. According to Open Minds, 21.7 million people are enrolled in programs in which companies providing managed behavioral health care are paid a fixed sum of, on average, $60 per capita annually to provide mental health and substance-abuse services.

An important characteristic of this business is that smaller companies are rapidly consolidating into ever-larger enterprises, a number of which are owned by insurance companies. The ranking of the largest firms in the industry has changed in each of the past three years, reflecting frequent mergers and acquisitions. Now, the 10 largest concerns generate an estimated 90 percent of the total revenue collected by this industry. The history of American Biodyne, known in the industry for its aggressive tactics in dealing with providers, mirrors this trend.[15] Renamed Medco Behavioral Care Corporation in 1993 after its purchase by Medco Containment Services, the firm changed hands again last July when it was bought from Merck, Medco's parent company, for $340 million. It has been renamed again since this transaction.

In a growing number of instances, the behavioral health care companies are forming integrated delivery systems, thus linking the functions of direct provision of care and plan management. By so doing, these companies increase their vertical integration and create potential conflicts of interest by combining the roles of provider and manager in one for-profit enterprise. One recent example of such a transaction occurred in October 1995, when Charter Medical Corporation, the largest for-profit provider of mental health care, purchased Green Spring Health Services, a firm that contracts to provide managed behavioral health care and that is owned by six Blue Cross and Blue Shield plans.[16]

Performance of the Plans

The performance of the companies providing managed behavioral health care is a source of controversy among many providers and some patients because it includes direct intervention into clinical decision making. By contrast, many private payers (such as employers and labor unions) seem quite satisfied with the value they receive from these companies. The most important indicator of performance, as measured by a payer,

is whether such a company has reduced the costs of providing behavioral health services. Today, most large corporations are self-insured with respect to medical expenses but usually use private carriers to administer benefits. The vast majority of corporations now assign (or "carve out") their behavioral health coverage by contracting with these specialized companies.

IBM was among the first of the large corporations to contract with a vendor of managed mental health care, because its costs for these services in the late 1980s rose even more rapidly than its general medical expenditures. After IBM signed its first such contract in 1990, its mental health expenditures declined from $97.9 million in 1992 to $59.2 million in 1993.[17] Other major corporations, such as Chevron, Dupont, Federal Express, Pacific Bell, and U.S. West, all have reported reductions of 30 to 50 percent in their expenditures for behavioral health services. Given the trend toward reduced expenditures for inpatient care, a number of companies have increased the flexibility of the benefits by eliminating certain coverage limits on outpatient services.

Helen Darling, manager of health care strategy and programs for Xerox, said in an interview that the company is

> well satisfied with our managed behavioral health vendor because it was instrumental in reining in an explosion of costs and service utilization that we experienced in the late 1980s and early 1990s. The mental health and substance-abuse utilization rates of our employees and retirees looked more like what you would expect to see among Medicaid's chronically mentally ill population. Now, Xerox employees have better access to a variety of alternatives to hospitalization, but medical necessity [*Author's note:* for a discussion of medical necessity, see Sabin and Daniels.[18]] is more strictly defined when it comes to borderline cases that represent life-adjustment problems such as divorce.

Table 1 shows a decided reduction in hospital admissions, inpatient days, and average length of stay per 1000 employees and in the costs of mental health and substance-abuse services between 1987 and 1994. The use of outpatient services, however, stayed about the same during this period.

The rise of the specialized companies has become a major competitive threat to many health maintenance organizations, forcing some to consider improving their behavioral health benefits. This year, the state of Ohio signaled its dissatisfaction with such coverage by health maintenance organizations by signing a contract with a behavioral health care company to provide services to state employees. In northern California, where it has 2.4 million members, the Kaiser Permanente Medical Care Program, a large, nonprofit health maintenance organization, is investing $100 million over a period of five years (1993 to 1997) to upgrade its behavioral health care, a neglected service within the plan. This decision was reached in large part because many of its largest corporate and labor-union customers (for example, Bank of America, Chevron, Pacific Bell, Wells Fargo, and the Teamsters' Union) had signed contracts with companies providing managed behavioral health care starting in the mid-1980s, having deemed Kaiser's mental health coverage inadequate. As a result, these customers were, in effect, paying twice for the services, a situation that led some of them to demand reductions in insurance premiums and to question Kaiser's claim to being a fully integrated plan. In response to the competitive threat that the specialized companies pose, Kaiser Permanente is in the midst of substantially upgrading mental health and substance-abuse services in its northern California region. In the process, the plan has begun to realize medical cost savings from providing a broader array of lower-cost behavioral health services. Kaiser's program in the southern California region, with an additional 2.2 million members, is expected to pursue a similar path soon.

Table 1. Use of Mental Health and Substance-Abuse Services by Employees of the Xerox Corporation and Average Benefits Paid by the Company, 1987 to 1994.*

VARIABLE	1987	1988	1990	1993	1994
No. of hospital admissions/1000 employees	9.7	9.6	9.5	6.1	6.1
No. of hospital days/1000 employees	327	276	307	77	61
Average length of stay (days)	33.7	28.9	32.5	13	9.9
Average payment for mental health and substance-abuse services ($)	377	357	587	268	214

*Data are from the Xerox Corporation.

MIXED VIEWS AMONG PSYCHIATRISTS

Whereas private payers have been attracted to the capacity of companies providing managed behavioral health care to reduce their mental health and substance-abuse expenses, psychiatrists have decidedly mixed views on the emergence of this market-driven phenomenon. The application of managed-care principles to mental health and substance-abuse services has provoked unprecedented turmoil in the profession by eroding the autonomy of practitioners, squeezing their incomes, and forcing them into constricted new roles. The sharp division within the psychiatric community over managed care was underscored last year during the campaign preceding the election of a new president of the American Psychiatric Association, which has 38,000 members.

Two Maryland-based psychiatrists, Dr. Harold I. Eist, a solo practitioner in Bethesda, and Dr. Steven S. Sharfstein, chief executive officer of the Sheppard and Enoch Pratt Health System, a large, nonprofit mental health facility in Baltimore that is built around a psychiatric hospital, vied for the post in an unusually heated race. Although Sharfstein is a far more prominent figure nationally, Eist campaigned aggressively on an anti–managed-care platform, accusing Sharfstein of selling out to the forces that are promoting this mode of delivery.

Reflecting Sharfstein's policies, Sheppard and Enoch Pratt has reduced its hospital beds from 320 to 200

since 1992, cut the average hospital stay from 50 to 14 days, and expanded nonresidential treatment programs on and off its grounds. The system has also contracted with Kaiser Permanente to provide services to its 40,000 enrolled members in Baltimore for a fixed per capita sum. Sharfstein said, "We are trying to cope and survive," conceding that the policies of the facility now reflect a more competitive marketplace. "We have begun to discharge patients to homeless shelters. That is a new phenomenon." During his campaign, Eist painted the contract with Kaiser Permanente as a sellout to managed care. By pledging to fight for state and federal legislation that he believes would curtail the incursion of managed care into psychiatric practice, Eist won the position of president-elect of the American Psychiatric Association by a vote of 7762 to 7391.

Academic departments of psychiatry are also feeling the economic pinch, because managed care relies heavily on primary care physicians, psychologists, and social workers and limits access to psychiatrists.[19] As in other specialties, academic psychiatrists are usually not included in the provider networks of managed-care plans because they are thought to be too expensive. The emergence of managed care may also be exacerbating the continuing difficulty that departments have experienced in filling residency positions, particularly with graduates of American medical schools. In the 1995 match-up of graduating medical students and residency positions, 750 of the 960 slots offered were filled, 218 of that number by foreign medical graduates. In 1990–1991, 78 percent of all psychiatric residents (4540 doctors) were graduates of American medical schools. By 1994–1995, only 65 percent (3909) were graduates of American schools.[20]

Academic departments of psychiatry and managed-care companies have not really begun to address their convergent interests.[21] But as competition increases, these companies will be challenged to demonstrate that their less expensive approaches also lead to successful outcomes. Besides lowering costs, managed-care companies are currently judged mostly on process-related measures, such as how quickly their case reviewers answer a patient's telephone call or the numbers and types of providers in their networks.

Little is known about how the various payment approaches affect the provision of care or whether treatment outcomes are improving or declining as a result of the greater use of nonphysician providers in the companies' networks. A few managed-care companies and some academicians have begun to recognize the paucity of information available. Representatives of five companies met recently in Washington with faculty members from eight universities to discuss training and research issues that apply to mental health and substance abuse. The American Managed Behavioral Healthcare Association recently announced plans to develop a "report card" that would reflect the performance of its member companies on four measures: access to care, patient and provider satisfaction, quality of care, and outcomes of treatment. Explaining the rationale, Dr. Peter Panzarino, medical director of a behavioral health care company in San Diego, California, wrote recently that employers are looking "for ways to measure the value of the services they purchase, rather than to make vendor selections based solely on price."[22]

The Movement to Managed Care in Medicaid

States have a central role in providing mental health care, one that far exceeds their role in the delivery of other medical care services.[23] Historically, state mental health authorities have operated with categorical program budgets (with a strong emphasis on inpatient care) derived from an appropriation of public funds for the mentally ill. Now, these authorities manage a complex array of services funded by a variety of federal, state, and sometimes local sources. The single largest payer for state-financed mental health care is Medicaid.

Many states are beginning to move their Medicaid populations into managed-care plans,[24-27] a policy that enjoys bipartisan support in Washington and in many state capitals, although it is controversial.[28-30] By June 1994, 7.8 million Medicaid beneficiaries were enrolled in health maintenance organizations and other managed-care plans, a number double that for the previous year.

With the mounting pressure on all levels of government to reduce their expenditures, state mental health authorities have begun to pursue the adoption of managed-care techniques and to sign contracts with behavioral health care companies. The companies view Medicaid as their next large market opportunity. Massachusetts was the first state to introduce a statewide managed-care plan for mental health services within its Medicaid program. Beginning in July 1992, the state enrolled some 375,000 disabled and nondisabled beneficiaries in a managed-care program. The state contracted with a private company, MHMA, to manage Medicaid's mental health coverage. An evaluation of the program, as required and underwritten by the Health Care Financing Administration, was conducted by researchers at Brandeis University. They found that mental health expenditures were reduced by $47 million, or 22 percent of the levels predicted without managed care; they also found no overall decrease in access to services or in the quality of care.[31]

Conclusions

Behavioral health care companies have demonstrated a capacity to achieve substantial savings in managing mental health services for employed people with private insurance, although the impact of such companies on the autonomy and role of psychiatrists has been substantial.[32] Many private payers are well satisfied with these results, but little is known about how these lower-cost treatments are affecting the mental health and lives of patients. Another consequence of the tighter control of mental health expenditures is its very real potential for stifling the development of new

drugs and other clinical improvements that could benefit the mentally ill.

As Medicaid, too, turns increasingly to managed care, for-profit companies will be challenged to achieve their bottom-line objectives and still provide adequate care for the many poor beneficiaries who suffer from severe and persistent mental illness. Before long, states will assume command of their Medicaid programs with far fewer federal regulatory constraints than in the past. The competition for shrinking Medicaid resources is certain to grow more intense. A crucial question is whether people with chronic mental illness in the United States will receive an adequate share of the available Medicaid funding when managed care becomes the chief method of rationing.

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MULTIMODALITY THERAPY OF CHEST MALIGNANCIES — UPDATE '96

Directed by David J. Sugarbaker, M.D.; Arthur T. Skarin, M.D.; Elizabeth A. Baldini, M.D., M.P.H.; Anthony D. Elias, M.D.; Malcolm M. DeCamp, M.D.; Gary M. Strauss, M.D.; and John J. Reilly, Jr., M.D. of the Brigham and Women's Hospital, Dana-Farber Cancer Institute, and Harvard Joint Center for Radiation Therapy

This symposium provides a comprehensive review of the new diagnsotic and therapeutic modalities in thoracic oncology by experts in the field. Important new clinical trials in multimodality therapy of non-small cell lung cancer and esophageal cancer are discussed. At the conclusion of this program, participants will be able to: identify the optimal diagnostic and staging studies for lung and esophageal cancer; select patients appropriate for multimodality therapy for their malignancy; identify candidates for experimental trials in the management of thoracic cancers; integrate current basic science advances into the diagnosis, staging and prediction of prognosis for patients with thoracic malignancy; evaluate patients with advanced disease who would benefit from palliative surgical, radiation or medical intervention.

Fee: $425 (U.S.); Residents and Fellows in Training (with verification): $200 (U.S.)

April 18–21, 1996

STROKE: UPDATE AND COMPREHENSIVE REVIEW

Directed by Frances E. Jensen, M.D. and Philip Stieg, M.D., Ph.D. of the Brigham and Women's Hospital

This course presents current diagnostic and treatment information related to cerebrovascular disease. Stroke, the most frequently encountered neurological disorder which practitioners of all types must confront, brings together a variety of clinical entities. This course provides a multidisciplinary update on topics relevant to the diagnoses and management of cerebrovascular disease. A case analysis at the end of the course provides a practical workshop for those who must treat cerebrovascular diseases. Upon completion of this program, participants will be able to identify the major categories of stroke; select neurodiagnostic tests based on currently available data; treat the major stroke syndromes in a current, up to date fashion.

Fee: $475 (U.S.); Residents and Fellows in Training (with verification): $375 (U.S.)

April 21–26, 1996

INFECTIOUS DISEASES OF ADULTS

Directed by Jay A. Fishman, M.D. and Stephen B. Calderwood, M.D. of the Massachusetts General Hospital

This course provides an in-depth and up-to-date synthesis of major advances in the field of clinical infectious diseases. Upon completion, participants will learn the latest strategies for the prevention, recognition, diagnosis, and treatment of important syndromes in infectious diseases. Participants will also be able to establish a differential diagnosis and initiate an appropriate diagnostic evaluation for the major infectious disease related problems in clinical practice. Topics with major impact on clinical practice are emphasized, including: parasitic emergencies, sexually transmitted diseases, AIDS in women, endocarditis, skin and soft tissue infections, new viral pathogens, antibiotic resistance, rabies, molecular diagnostic methods, infections of travelers, and the reemergence of tuberculosis.

Fee: $675 (U.S.); Residents and Fellows in Training (with verification): $450 (U.S.)

April 22–24, 1996

SELECTED TOPICS IN EMERGENCY MEDICINE

Directed by J. Tobias Nagurney, M.D., FACEP; David F.M. Brown, M.D.; and Everett T. Lyn, M.D. of the Massachusetts General Hospital

The objective of this course is to review selected topics of relevance to the practicing emergency physician with emphasis on the priorities and recent advances in initial assessment and treatment. At the conclusion of this course, attendees will be able to apply up-to-date clinical strategies to the diagnoses and management of common problems presenting to the emergency physician. This year, pediatrics and trauma will be highlighted. The format for the last two afternoons will be smaller group electives in a variety of topics with an opportunity for interaction with the faculty. Question periods are provided after all presentations throughout the course.

Fee: $495 (U.S.); Residents/Fellows in Training (with verification) Emergency Nurses and Physician Assistants: $425 (U.S.)

April 24–25, 1996

THE FIRST HARVARD SYMPOSIUM ON THE MEDICAL CONSEQUENCES OF TERRORISM

Directed by Susan M. Briggs, M.D. of the Massachusetts General Hospital

Terrorism continues to menace civil society. Recognition of the potential types of injuries from terrorist attacks presents a significant challenge to physicians involved in disaster response. This course is designed to identify the threats, elucidate the medical consequences and define appropriate medical responses to injuries from terrorist attacks. Using a nationally recognized faculty, the course will provide a timely update on selected aspects of injuries from nuclear, biological, chemical and conventional weaponry and the management of such injuries..

Fee: $325 (U.S.); Residents/Fellows in Training (with verification), and Other Health Professionals: $125 (U.S.)

April 29–
May 3, 1996

COMPREHENSIVE REVIEW OF GASTROENTEROLOGY

Directed by Drs. Stephen Goldfinger, John Gollan, J. Thomas Lamont and Daniel Podolsky

After completing this course, physicians will be able to: (1) describe advances and discoveries in the field of gastroenterology; (2) base decision-making on the relative value of various diagnostic tests and treatment options; (3) make strategic decisions in adapting to a managed care environment. Topics of particularly timely interest include: anti-viral therapy for chronic hepatitis, GI manifestations of HIV infection, endoscopic ultrasound, new therapies for IBD, helicobacter pylori update, advances in laparoscopic surgery and the managed care environment.

Fee: $810 (U.S.); Residents and Fellows in Training (with verification): $650 (U.S.)

At each course, a comprehensive syllabus is provided

_____ Payment enclosed. Please enroll me in:

Course: _____ _____ Please send further information on:

Dates: _____ Tuition: _____ (US Funds)

Full Name _____ (please print clearly)

Mailing Address _____ Daytime Phone ( )

(street) (city) (state) (zip)

Medical School Attended _____

Specialty _____ Year of Graduation _____

Other (if non-MD) _____ Board Certified: Yes ___ No ___

Degree _____

Mail full payment with completed application form to: • Harvard MED-CME• P.O. Box 825, Boston, MA 02117.
Telephone (617) 432-1525, Monday-Friday 10 a.m.-4 p.m. (Eastern Time).
A refund of tuition less $50 will be made if written notice of cancellation is received one week before the course begins. No refund will be made thereafter.

MAY 1996 GRADUATION CALENDAR

Mon., Jan. 8	First day to begin creating application in screen 117 for May '96 degree candidates.
Fri., Jan. 19	Last day for both undergraduate and graduate students to file with their Deans Office an application for degree to be awarded in May.
Fri., Jan. 26	O.U.R. mails the Special Ceremonies form to all dept/schools who have been approved for a May 1996 special graduation ceremony.
Mon., Feb. 19	Last day for degree candidates to submit name change with O.U.R.
Mon., Feb. 26	Last day for Graduation Coordinators to create applications in screen 117.
	Any application received after this deadline will not have their name appear in the Commencement Program or be included in the diploma order.
	O.U.R. requests potential distinction report to flag student record with distinction or highest distinction for diploma order.
Tues., Feb. 27	O.U.R. begins accepting any Late Graduation Checkout Notice forms from Graduation Coordinators.
	O.U.R. prints local address labels for Special Projects for mailing of information packet to candidates. Exclude DRPH, EDD, and PHD.
	Last day for O.U.R. to receive Special Ceremony Forms back from departments/schools.
	O.U.R. downloads degree candidate names to begin preparation of Commencement Program and diploma order.
Wed., Feb. 28	O.U.R. begins to write and test focus reports for Special Ceremonies.
	O.U.R. requests and distributes degree candidate reports to Graduation Coordinators; by alpha and by degree.
Mon., Mar. 4	O.U.R. mails diploma order to vendor.
Fri., Mar. 15	O.U.R. requests straight alpha degree candidate listing for Alumni Office and Student Aid Office.

Fri., Mar. 22	List of degree candidates due to Scott Jared for commencement program. Submit hard copy and diskette.
Wed., Mar. 27	O.U.R. requests and distributes degree candidate reports to Graduation Coordinators; by alpha and by degree.
Wed., April 3	O.U.R. receives first page proof of Commencement Program from Scott Jared.
Fri., April 7	All degree candidates taking their last requirements through correspondence must have taken their final exam by this date.
Mon., April 8	First page proof of Commencement Program due back to Scott.
	O.U.R. expects receipt of diploma order from vendor.
	O.U.R. requests and sends labels to Transportation and Parking.
Mon., April 15	Deadline for O.U.R. to receive Honors List from Sue Hester.
Wed., April 17	Final page proof of Commencement Program due to Scott Jared.
Thurs., April 18	Deadline for Arts & Sciences to complete entry of degree requirements.
Fri., April 19	O.U.R. sends memo to Physical Plant including list of degrees to be awarded so that they may check their sign inventory. Include August and December degrees as well.
Mon., April 22	O.U.R. downloads degree candidates with diploma STOPS. Sends STOPS roster to STOPS offices. Sort: Stops office, include memo from O.U.R.
	O.U.R. downloads degree candidates with diploma STOPS. Sends STOPS letter to student's grade/billing address.
Wed., May 1	O.U.R. requests and distributes degree candidate reports to Graduation Coordinators; by alpha, by degree, and degree requirements.
Wed., May 8	Run STOPS reports for Cashier/Phyllis. Three sorts: Alpha, Stops Office, and Degree.
	Last day for school deans to submit retro-active academic actions for degree candidates (i.e. grade changes, drop/adds, major changes, etc.).

	Last day for Graduation Coordinators to post minors to a degree application.
Thurs., May 9	Last day for Graduation Coordinators to set checkout status to "3". O.U.R. will not accept any late "Clears" until Monday, May 13.
	O.U.R. requests Special Ceremony reports for the purpose of pulling diplomas.
	O.U.R. finishes marking and filing distinction and honors on diploma inserts by end of day.
	O.U.R. finishes setting honors and distinction flags in SIS-C database.
	O.U.R. requests and distributes degree candidate reports to Graduation Coordinators; by alpha, by degree, and degree requirements.
Fri., May 10	Assistant to the University Registrar finishes pulling all diplomas for candidates that have diploma STOPS by noon today.
	O.U.R will begin to pull diplomas for candidates that have not been cleared for graduation, checkout status 2 and 4.
Sat., May 11	O.U.R. completes pulling diplomas for candidates that have not been cleared for graduation, checkout status 2 and 4.
	O.U.R. pulls diplomas for Special Ceremonies.
	O.U.R. prepares Room 105, Hanes Hall for diploma distribution on Commencement Day.
Sun., May 12	May Degree Award Date
the	Offices approved for special ceremonies may pick-up diplomas between hours of 7:30 AM and 9:00 AM in 105 Hanes Hall.
	Deadline for completion of requirements to qualify for May graduation.
	O.U.R. distributes diplomas for Arts and Sciences departments not having a special ceremony.
Mon., May 13	Any diplomas not distributed by special ceremony departments will be returned to O.U.R. by 9:00 AM. At 11:00 AM O.U.R. will begin to distribute all remaining diplomas.

Wed., May 15	First degree posting to student record in screen 123.
	O.U.R. requests and distributes degree candidate reports to Graduation Coordinators; by alpha, by degree, and by checkout status.
Wed., May 22	Second and final posting to student record in screen 123.
Thurs., May 23	O.U.R. requests and distributes degree candidate reports to Graduation Coordinators; by alpha, by degree, and by checkout status.

JOHN HATCH SCHOLARSHIP FUND

1st Tier: Major Gift Prospects and Community Mobilizers

J. R. Manley
Ted Parrish
Jack Geiger - good source of info
knows foundations well.
Ruth Mott - elderly, may be difficult to get to
Appropriate to write letter to her at some point
Should try and get to her directly
Robert Hatch
Allan Hatch
Colin Greer - knows many people in fdn world, could be helpful
John Turner - School of Social Work
Cecil Shepp - endorsement may be useful
LC Dorsey - Jackson State School of Social Work (Jackson, MS)
Aaron Shirley - Director of Network Health Services (recip. of MacArthur Foundation Genious Award) (Jackson, MS)

Howard Lee - doesn't belong in this group
major loyalty to Social Work
doesn't know well

3/21/96

Tecola Fissel
Anita Holmes
Marcus Eure
Wanda Woods
Curtis Jackson

* Contact Mrs Barnhill ASAP

JOHN HATCH SCHOLARSHIP FUND

2nd Tier

Marion Wright Edelman (Children's Defense Fund)
Husband Peter (Shalala's Deputy), fmr mbr. of New World
John knows him better than Marion
Walter Isaacs - Schenectady, NY
Frances Stephens (Mississippi)
Clay E. Simpson
Kellogg Fdn (Carolyn?)
Dr. Craig (Baptist State Conv(?))
Dr. Cheney - KY State
Rockefeller Fdn: Robert Lawrence
fmr faculty here
Howard Fitts
Margaret Pollard
Eva Clayton
St. Mark's A.M.E. Zion - Durham
Floyd McKissick, Jr. - Durham
Vernellia Ruth Randall
Tony Whitehead
Kenan Foundation

JOHN HATCH SCHOLARSHIP FUND

3rd Tier

Dir. of Mississippi Delta Community Health Ctr. - Seymour Mitchell
NC Mutual (who is contact?)
New World Fdn
Freedom From Hunger Fdn. - inform Board Members, former Brd. Mbrs who would know John
org. won't have $
Noreen Clark, Dean of SPH of U. of Michigan
William Darity
Stanford Roman (Dean, CUNY Medical School)
Caswell Evans
Rubin Warren (CDC)
Carnegie - Linda Randolph headed up Task Force on Children, Find out where she is now

JOHN HATCH SCHOLARSHIP FUND

Other

HBHE Colleagues
Faculty Emeriti
Alumni
Current Students
Int'l

- South Africa
- Brazil
- Zimbabwe
- Uganda (Ministry of Hlth frmr student)

M E M O R A N D U M

DATE: October 16, 1995

TO: **MINORITY HEALTH CONFERENCE PLANNING COMMITTEE**

FROM: Buffa French

RE: Tentative Conference Schedule

CC: Dean Small

Healthy People of Color 2000: Intervention Strategies--update...

The following is a tentative schedule of events for the Minority Health Conference. The committee invites any comments and suggestions to this attempt to shape things up. Any additional breakout session topic areas are welcomed, along with suggestions on who can lead the sessions.

WEDNESDAY NIGHT

Dinner with Keynote Speaker and Students

THURSDAY

8:00-8:30 **Registration**		
8:45-9:45 **Opening Speaker**		
10:00-10:45 **Migrant Health**	**Mental Health**	**Grant Writing**
11:00-11:50 **Violence**	**International**	**Grant Writing**

LUNCH: 12 NOON-1:15 Speaker

1:30-3:00 **Student Presentations** **10 minute presentations x 7**
3:15-4:15 **Careers in Public Health**

FRIDAY

9:00-10:00 **Speaker**		
10:15-11:00 **Community Based Programs**	**Substance Abuse**	**Grant Writing**
11:15-12:00 **Community Based Programs**	**Substance Abuse**	**Grant Writing**

In addition to your comments and suggestions, please put in Howard Straker's box (in the HBHE Dept. on 3rd floor), any progress made on your assigned topic areas. A preliminary flyer is going out next week as a conference announcement and will include the following information:

- students are invited to present papers and/or posters on their work in progress.
- the job/career fair (this item is still being discussed)
- topic areas: mental health; migrant health; international health; community-based prevention programs; and substance abuse.

HEALTH POLICY REPORT

POLITICS AND PUBLIC HEALTH

JOHN K. IGLEHART

THE rush to shrink the federal government and reduce its costs, propelled by the Republican-controlled Congress with the reluctant acquiescence of the Clinton administration, has begun to change the Public Health Service and other federal health agencies in important ways. The Republicans have begun to dismantle the offices of the assistant secretary for health and the surgeon general, as well as the Office of Technology Assessment (OTA); reduce funding for substance-abuse treatment, mental health services, and health services research; and consolidate many other public health programs. However, the House of Representatives has voted to continue Congress's long-standing commitment to the National Institutes of Health (NIH) by appropriating even more money for biomedical research in fiscal year 1996 than was requested by the Clinton administration.

These developments are only the opening scenes of a policy drama that will unfold in 1996 and thereafter, as Republicans place their more conservative stamp on government. The Republican party, its policies increasingly driven by its right wing, is determined to press the role of individual responsibility as it applies to the contentious issues of personal behavior and public health. But in 1995, the first year in four decades that Republicans controlled the Congress, Republican lawmakers devoted only limited attention to these matters. Instead, they concentrated on approving a plan that would erase the massive federal deficit in seven years. In the health care sphere, as a consequence, Republicans focused on slowing the growth of the two largest federal health programs: Medicare[1] and Medicaid.[2] These two programs account for about 80 percent of annual federal health care expenditures (which totaled $335 billion in fiscal year 1995). The remaining health care costs are divided mostly among the eight Public Health Service agencies ($22.4 billion), the Department of Veterans Affairs ($17.3 billion), the Department of Defense ($10 billion), and the Environmental Protection Agency ($7.3 billion).

THE PUBLIC HEALTH SERVICE

The Public Health Service has a distinguished history that dates back to the late 1700s, when many merchant seamen arrived ill and unattached in American port cities that had little capacity to care for them.[3] In 1798, adopting the British tradition of caring for sick mariners at public expense, Congress enacted a measure, which President John Adams signed into law, that provided for "the temporary relief and maintenance of sick or disabled seamen." The first hospital dedicated to the care of merchant sailors was a building purchased near Norfolk, Virginia, in 1801. The first public hospital actually built with tax revenues, however, was in Boston.

Since that time, almost 200 years ago, the Public Health Service has grown to prominence as a federal enterprise dedicated to promoting and protecting the public's health, with a mandate that often embroils its agencies in controversy. The eight agencies of the Public Health Service are the Agency for Health Care Policy and Research, the Agency for Toxic Substances and Disease Registry, the Centers for Disease Control and Prevention (CDC), the Food and Drug Administration (FDA), the Health Resources and Services Administration, the Indian Health Service, the NIH, and the Substance Abuse and Mental Health Services Administration. Table 1 shows the spending trends of these agencies in recent years.

Three different sets of House and Senate committees authorize laws governing the Public Health Service, establish overall spending ceilings, and appropriate moneys annually for program operations. The House Commerce Committee and the Senate Labor and Human Resources Committee establish many of the overall policies of the eight agencies through the Public Health

Table 1. Appropriations for Public Health Agencies in 1985, 1990, and 1994 and Proposed Appropriations for 1996.*

AGENCY	APPROPRIATION			PROPOSED 1996 APPROPRIATION			
	1985	1990	1994	PRESIDENT	HOUSE	SENATE	CONFERENCE
	millions of dollars						
NIH	5,554.3	8,510.4	10,947.6	11,764.1	11,939.0	11,597.5	
Health Resources and Services Administration	1,492.3	1,748.9	2,936.6	3,099.3	2,929.8	2,953.8	
Indian Health Service	915.3	1,081.6	1,943.1	2,059.0	1,962.8	1,966.6	1,961.8
Substance Abuse and Mental Health Services Administration	596.7	1,683.9	2,150.2	2,224.4	1,788.9	1,669.9	
CDC	457.6	1,121.3	2,051.1	2,191.7	2,124.9	2,091.9	
FDA	415.6	601.0	873.0	883.6	881.6	874.6	878.4
Office of assistant secretary for health	38.5	53.2	67.2	66.2	34.4	41.3	
Agency for Health Care Policy and Research	17.5	55.8	141.2	148.2	65.5	127.3	
Agency for Toxic Substances and Disease Registry	14.6	45.2	67.0	68.0	62.0	54.0	

*The appropriations shown are the funds approved by Congress for agency operations in the fiscal years shown. Several Public Health Service agencies have additional sources of income. The FDA and CDC collect fees from industry. The Indian Health Service collects health insurance payments from patients with coverage. The Agency for Health Care Policy and Research receives "1 percent evaluation" funds, which are appropriated initially to other Public Health Service agencies. Since the FDA and the Indian Health Service receive their appropriations through another bill that has already become law, their final appropriations for fiscal year 1996 are shown under the heading "Conference." Data are from the Department of Health and Human Services.

Service Act. The House and Senate budget committees set overall annual spending ceilings for all government agencies, including the Public Health Service agencies. The House and Senate appropriations committees, and particularly their relevant subcommittees, approve annual spending levels under these ceilings.

Reforming an Unwieldy Structure

The Public Health Service agencies operate hundreds of small categorical grant programs, the result of political forces that have dominated federal health policy since World War II. These forces favor the creation of narrowly targeted programs to address a multitude of specific health problems, rather than the enactment of more general programs that could, for example, provide universal access to medical care or address other broad needs. During the past three decades, Congress, the public health agencies, and countless private-interest groups have been parties to the creation of this unwieldy structure. Dr. Philip Lee, assistant secretary for health and scientific affairs in the Department of Health and Human Services, described it thus during testimony on March 8, 1995, before the Senate Labor and Human Resources Committee:

> Between the early 1970s and 1992, there was steady growth in small categorical programs which addressed special health care needs. Although each met a perceived need, the abundance of narrowly-focused health professions authorities today limit the government's flexibility to prioritize limited funding and respond effectively to emerging health workforce challenges. We believe the current categorical grant system has come to place unreasonable administrative burdens and costs on grantees and federal administrators.[4]

Lee's testimony referred to 44 separate federal training programs, many of which were established to increase the numbers of medical, nursing, and allied health personnel. In a 1994 report, the General Accounting Office concluded that although the supply of trained personnel in nearly all the health care professions had increased faster than the population, no data were available to demonstrate that the increased supply had improved access to care in underserved rural and urban areas or minority representation among trainees.[5] Now, both Congress and the administration favor consolidating these 44 categorical programs into some half-dozen general programs designed to promote primary care, advanced-practice nursing, the National Health Service Corps, and the representation of minorities in training programs.

The administration has also proposed consolidating other categorical programs administered by the CDC and the Substance Abuse and Mental Health Services Administration. This proposal emerged as part of the initiative led by Vice-President Albert Gore to reinvent government. But rather than accept the preference of most Republicans to convert federal categorical grant programs into block grants with few strings attached, the administration has proposed a new approach: "performance partnership grants." With this approach, the states would have greater control in setting priorities for the expenditure of federal funds but would be held accountable for their performance. A state's performance might be measured, for example, against the goal of increasing the proportion of two-year-old children who have a complete series of vaccinations or reducing the number of deaths caused by alcohol-related automobile crashes.

The Power of the Purse

Because the two authorizing committees devoted only limited time to the public health agencies in 1995, the actions of the House and Senate appropriations committees provide the clearest early glimpse of Republican priorities as the party reshapes and reduces the federal investment in public health. Indeed, the first health-related casualty of the Republicans' zeal to shrink the government came at the initiative of Senator Connie Mack (R-Fla.) in his capacity as chairman of the Senate Appropriations Subcommittee on the Legislative Branch. Mack successfully pressed for the abolition of the OTA, a small agency (annual budget, $22 million) created by Congress in 1972 to advise the legislative branch on a wide range of critical issues involving science and technology. In an interview, I asked the OTA's director, Dr. Roger Herdman, why the agency was eliminated. Herdman responded:

> Republicans decided to reduce spending of the legislative branch by 10 percent — about $200 million. But why OTA? I concluded that it must have been because Republicans did not believe it was necessary for Congress to have its own agency that provided independent technical and scientific information and analysis. They felt perfectly content to obtain their information from private sources whose interests were expressed by the advice, or, put another way, had their own axes to grind.

The most important action in relation to appropriations for health care programs is the House approval, on August 4, 1995, of a bill that funds the Labor, Health and Human Services, and Education departments, as well as related agencies. Passed by a mostly party-line vote of 219 to 208, the bill sets fiscal 1996 appropriations for these agencies at $261.9 billion, which is $11.1 billion less than the amount sought by the administration. A total of $18.8 billion is appropriated for discretionary health care programs in 1996, which is about the same amount as in 1995. The bill eliminates most of the 163 job-training programs operated by the Department of Labor and 50 other programs run by the Department of Education (resulting in a savings of $4.9 billion). On September 15, 1995, the Senate Appropriations Committee reported a counterpart bill that provides $18.4 billion for the same public health agencies. But several senators have barred its consideration by the full Senate because of their opposition to riders attached to the bill that are unrelated to health care. If this blockage continues, the public health agencies will be forced to operate at lower spending levels with stopgap funding.

The bills approved by the House and reported by the Senate Appropriations Committee that apply to the

public health agencies were actually fashioned by the key subcommittees on these matters. The new Republican chairs of these subcommittees, Senator Arlen Specter of Pennsylvania and Representative John Porter of Illinois, are political moderates. Specter, who votes with the Clinton administration about half the time, is prochoice on the question of abortion and supports biomedical research and the Human Genome Project. Porter accentuated his long-standing commitment to the NIH shortly after becoming the subcommittee's chairman, characterizing the agency as "a U.S. national treasure."[6]

However, Porter's strong support of the NIH came at the expense of other public health agencies. One of the hardest hit was the Substance Abuse and Mental Health Services Administration. The bill passed by the House provides $1.8 billion for this agency in 1996, which is $392 million below its appropriation the previous year and $436 million less than the administration requested. The House Appropriations Committee noted in its report on the bill: "The responsibility for providing substance abuse and mental health services rests primarily with state and local governments, and the private sector."[7] The Senate committee's bill appropriates $554 million less for the agency than was requested by the administration.

Both the House and the Senate bills eliminate the office of the assistant secretary for health in the Department of Health and Human Services. (The House bill also eliminates the office of the surgeon general, but the Senate bill does not.) The administration had been planning to dismantle the office of the assistant secretary for health, because since the Social Security Administration became an independent agency in 1995, few agency heads still report directly to the secretary, but the Republicans have forced the issue. With a proposed 1996 budget of $66.2 million and some 1000 employees, the office of the assistant secretary of health coordinates activities involving both the secretary of health and human services and the public health agencies. The office also oversees special programs created by Congress to demonstrate its concern about particular problems, such as AIDS, integrity in research, emergency preparedness, women's health, the health of minorities, vaccination policies, and disease prevention and health promotion. If the office is eliminated, most of these functions will be maintained, but under the direct purview of the secretary of health and human services.

In response to the Republican plan to abolish the office of the assistant secretary, Health and Human Services Secretary Donna Shalala published a notice November 9 in the *Federal Register* announcing the creation of the Office of Public Health and Science within her office.[8] The new office, to be directed by Philip Lee, will have a staff of about 300 people, which is one third the size of Lee's current staff. The notice also designates the Public Health Service agencies as operating divisions reporting to the secretary, thus eliminating a bureaucratic layer and Lee's direct authority over the agencies. As a consequence, for the first time in almost three decades, the agencies will be directly accountable to a nonphysician.

When Lee appeared before Porter's subcommittee on March 8, 1995, the Republican chairman characterized the office of the assistant secretary as "a muscular, middle-management bureaucracy, which in our experience hinders rather than facilitates the free flow of information and good decision making" between Congress and the public health agencies. But politics was also at play. Lee's office included 14 deputy assistant secretaries and 6 special assistants — a staff regarded by Republicans as a liberal cadre continually advocating an expansion of the federal role in health. Lee had filled a number of these positions with political appointees who had lost their influential legislative posts when the Republicans took control of Congress.

Biomedical Research

The House and Senate appropriations committees have long been the congressional champions of biomedical research, approving funding levels exceeding the appropriations requested by virtually all recent administrations, Democrat and Republican. This record will continue with the Republican Congress, but the appropriations may well be trimmed, given the Republican party's relentless assault on the budget deficit. Before the two appropriations committees acted last year, the House and Senate budget committees had called for a 10 percent reduction in funding for the NIH. Overcoming this early threat, the House-approved appropriations bill provides $11.9 billion for the NIH in fiscal year 1996, or $655 million (5.8 percent) more than was allocated the previous year. With inflation currently running at an annual rate of 4.3 percent, the House appropriation provides the stable financial base called for recently by the director of the NIH, Dr. Harold Varmus,[9] and is $175 million more than the amount sought by President Bill Clinton. During the House debate on August 2, 1995, Porter emphasized that beyond providing more money, the bill would also eliminate congressionally earmarked research funding "and leave the funding priorities not to political considerations, but to science."[10] The Senate Appropriations Committee approved only $11.6 billion for the NIH, an amount that would slightly erode the agency's current purchasing power. The recently announced retirement plans of the committee's chairman, Senator Mark Hatfield of Oregon, will eliminate from the Republican ranks one of the party's most respected moderates and a champion of the NIH.

Disease Surveillance and Control

In the process of approving funds for the CDC, the Republicans had two priorities that are reflected in many of their efforts to change the structure of the federal government: devolving greater authority to state and local governments, which already receive about 75 percent of the CDC's funds, and consolidating small categorical grant programs into more flexible blocks of support. Within this context, the House-approved ap-

propriations measure includes increased funding for childhood immunizations, screening for breast and cervical cancer, and the prevention of sexually transmitted diseases and chronic and environmental diseases, but the overall appropriation of $2.1 billion is $66.8 million less than the amount requested by the Clinton administration. The Senate bill provides funding for the CDC that is $33 million less than that provided by the House bill.

In the effort to bolster the role of state and local governments in public health, the House measure actually parallels the Clinton administration's top priority for the CDC. Testifying on March 9, 1995, before the House subcommittee, Dr. David Satcher, the CDC's director, said, "The CDC has taken that task as its number one priority — working with states and local governments throughout the country . . . to strengthen people in public health . . . to strengthen the laboratories . . . to strengthen the staff in terms of training [and] of epidemiology."

One CDC program that has escaped the appropriations process largely unscathed, despite efforts by the National Rifle Association and other groups to abolish it,[11] is the National Center for Injury Prevention and Control. The House and Senate appropriations bills both include $43.7 million for the center, which is about $1 million less than the amount requested by the administration. Although the center earmarks only $2.5 million a year for research on firearms, the National Rifle Association tried to eliminate the entire center. From 1988 to 1991, the rate of homicide among American males 15 to 24 years of age was 37.2 per 100,000. In Italy, the developed country with the second highest rate, it was 4.3 per 100,000.[12]

Health Services Research

Although the Republicans' funding priorities for the NIH and the CDC approximate those of the administration, Republican views on the value of health services research are decidedly different. The House committee recommended an appropriation of $125.5 million for the Agency for Health Care Policy and Research, which is $68 million less than the amount the administration requested and $33.9 million below the agency's current operating level. But on the House floor, Representative Sam Johnson (R-Tex.) won approval of an amendment that would transfer $60 million of the agency's funds to vocational and other educational programs and prohibit the transfer of $5.8 million in Medicare trust funds to the agency. Johnson characterized his amendment as a "first step toward the total elimination of this agency" next year. Johnson's amendment was accepted on a voice vote. The Senate committee's bill provides $127.3 million in funding for the agency.

The Agency for Health Care Policy and Research was targeted for elimination by Johnson and a fellow Texas Republican, Henry Bonilla, after they took up the cause of a small group of spinal surgeons who opposed the results of a study on low-back pain sponsored by the federal agency. A professional panel convened by the agency concluded that 9 of every 10 patients with acute back pain (as opposed to chronic, long-term pain) will recover within a month with virtually no treatment. The American Academy of Orthopedic Surgeons endorsed the finding, but the North American Spine Society condemned the back-pain study and launched a political attack against the agency. Dr. Robert Keller, an orthopedist in Maine who served on the agency's panel, said in a newspaper interview: "I think you can imagine the [study's] effect on [orthopedists'] income. But no one has published in a peer reviewed journal a rebuttal."[13]

Another issue involved the agency's role in the debate on health care reform, according to Gail Wilensky, who served as the top health policy aide to President George Bush and now consults extensively with Republican lawmakers. Wilensky, a health economist who worked in the National Center for Health Services Research before it was recreated as the Agency for Health Care Policy and Research in 1989, said in an interview:

> The Bush White House sought the agency's technical assistance during the development of its health policies, but its liaison was intransigent and refused to respond to our repeated requests. During the development of Clinton's reform plan the agency became very visible and helpful to the administration, providing advice at every turn. This contrast, I can tell you, was not lost on the Republican Congress.

The Changing Committee Leadership

Over the years, the public health agencies have been overseen by several congressional Democrats who in most instances advocated a strong federal role in public health. The two most influential figures were Representative John Dingell (D-Mich.), who greatly expanded the legislative reach of the House Commerce Committee, and Senator Edward Kennedy (D-Mass.), who chaired the Senate Labor and Human Resources Committee. The new Republican chairs of these two committees favor a more limited federal role in public health. Thus far, the contrast between these views has not been as sharp in the Senate as in the House. However, Senator Nancy Kassebaum (R-Kans.), a moderate who succeeded Kennedy as chair of the Senate Labor and Human Resources Committee, announced on November 20 that she would not seek reelection in 1996.

Assuming that the Republicans maintain control of the Senate next year, Kassebaum's successor may well be Senator Daniel Coats (R-Ind.), a staunch conservative whose values are deeply rooted in his religious faith. A lawyer, Coats formerly worked as an aide to Dan Quayle and succeeded him first in the House and then in the Senate, when Quayle was elected Vice-President. Strongly opposed to abortion, Coats has introduced legislation that would prohibit the Accreditation Council on Graduate Medical Education from requiring that residency programs provide training in induced abortions. Coats's target was a new set of requirements adopted by the council for the training of residents in obstetrics and gynecology. Both the council and the American Medical Association opposed Coats

proposal, characterizing it as an unprecedented and unwarranted federal intrusion into the medical-accreditation process. On another matter, Coats and conservative William Bennett recently launched the Project for American Renewal, which seeks to invigorate the country's civic and charitable efforts on behalf of the poor.[14]

In the House, Representative Thomas Bliley, Jr. (R-Va.), succeeded Dingell as chairman of the Commerce Committee, a powerful panel with jurisdiction over energy, environmental, health, financial, and telecommunications policies. A pragmatic conservative, Bliley opposes an active federal role in matters that he believes are better left to state and local governments or the free market. Shortly after assuming the committee chairmanship, Bliley took control at the level of the full committee, reducing the power and staffs of its once-formidable subcommittees.[15] For almost two decades, Representative Henry Waxman (D-Calif.) presided as chairman of the Commerce Subcommittee on Health and the Environment. From that post, he waged a campaign against smoking and smokeless tobacco. In contrast, Bliley, whose Richmond district includes thousands of employees of the cigarette manufacturer Philip Morris, opposes federal restrictions on tobacco and cigarettes.

Bliley's committee has jurisdiction over the FDA. Since both the House and Senate authorizing committees are determined to speed up the FDA's process for approving new-drug applications and rein in its activist commissioner, Dr. David Kessler, the committees will undoubtedly seek major legislative reforms in 1996. Whether the FDA is allowed to regulate the use of tobacco will also be an item on the congressional agenda. On August 10, 1995, President Clinton instructed the FDA to propose regulations, which it did on the same day, to curtail the sale, distribution, and advertising of cigarettes to minors. The administration's action met angry resistance from tobacco manufacturers, which went to court to try to block it.[16] The FDA's action against tobacco had no influence on its 1996 appropriation, which, for historical reasons, was contained in a bill that funded the Department of Agriculture.

Conclusions

With the ascendancy of the Republicans, most of the federal agencies that perform a wide variety of functions related to public health have been reduced. The priorities are limiting the scope of federal operations, devolving authority to state and local governments, and unleashing market forces as the favored method of allocating scarce resources. The full effect of these new priorities on public health agencies will not be known until later this year and thereafter, because the Republicans devoted their first year of congressional control to reducing the federal deficit. When they turn their full attention to these other matters, many Republican legislators are prepared to press their agendas more aggressively than they have to date.

The Republicans have demonstrated that they recognize the value of biomedical research and are prepared to provide funding for the NIH that will sustain the agency's activities and permit some growth. They have also expressed confidence that as the federal government shrinks, America's commitment to charity or, as former President Bush characterized it, "a thousand points of light," will grow. If the market-driven reforms of health insurance that the Republicans favor result in a continued decline in the number of persons with coverage,[17] or if state and local governments fall short of demonstrating the necessary capacity to administer a wide variety of programs for some of the most vulnerable people in our society, it is not clear what actions the Republicans will take. The answers to these questions will emerge as the Republican drive to reduce government accelerates.

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INFORMATION FOR AUTHORS

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Authors of research articles should disclose at the time of submission any financial arrangement they may have with a company whose product figures prominently in the submitted manuscript or with a company making a competing product. Such information will be held in confidence while the paper is under review and will not influence the editorial decision, but if the article is accepted for publication, the editors will usually discuss with the authors the manner in which such information is to be communicated to the reader.

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Authors should express all measurements in conventional units, with Système International (SI) units given in parentheses throughout the text. Figures and tables should use conventional units, with conversion factors given in legends or footnotes. In accordance with the Uniform Requirements, however, manuscripts containing only SI units will not be returned for that reason.

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From: 102LSLOAN@SOPHIA.SPH.UNC.EDU

Hello! I hope everyone had a great break! We discussed a number of things at the last meeting and some of it requires your input. So please read and respond appropriately.

Treasurer's report--We have $233.36 as of September 20. If you have not paid you dues, please do so. The dues are $10 a semester. You can even use an installment plan!

Committee reports--The social committee and fundraising committee are coming up with ideas for events. If you have any suggestions please e-mail fundraising to Nicole Bivins (102NBIVINS) and social to Jenique Thompkins (30JTOMPKINS). The mentoring committee met and discussed what should go in the letters to the alumni. We will tell them about the Cacus and some of our activities, then we will tell them of our expectations of the program: to have people to bounce ideas, foster professional relationships, assist in dissertations (by being on the committee), offer advise in the field about best career strategies, sharing their experiences, and networking. Their time committment will be minimal: phone calls, lunches, etc. The notes/test file committee is working on getting information on a permanent reserve at Health Sciences Library, so that people can copy and check out information on their own. The community service committee came up with a number of ideas working with the Nubian youth in Tillery. Among other ideas, they discussed the possibility of inviting the students to spend a day at UNC and possibly attend a game.

Minority Heatlh Conference--A number of ideas were presented. So far the theme is Healthy People of Color 2000: Are We on Track? Strategies Toward Our Destiny. There was some discussion about the length of the theme being too long. Also, possible keynote speakers are (forgive my spelling of names) Reed Tuxon, director of Charles Drew Medical School, Billeye Avery of Black Woman's Health Project, and Jocelyn Elders, former Surgeon General. The conference is on February 15-16, with the 15th being a full day and 16th a half day.

Name change--There was a very good discussion about the possibilty of changing

the Caucus's name. A number of people have expressed concern about the use of the word "minority" saying that it has a condescending and deragatory tone to it. Also, in a global sense, people of color are not the minority, but the majority. A number of people have suggested leaving the name as it is because people know who you are talking about when you say minority and "people of color" has some ambuguity. As a group, we need to discuss what changing the name of the organization will mean to us and to what would we like to change it, if we choose to follow this path. Changing the name will entail alot of discussion time, possibly in separate meetings from the general body meetings. We would also need to set a definite timeline. PLEASE LET ME KNOW HOW YOU FEEL. If there is not sufficient interest in changing the name or if people feel strongly in leaving the name as it is, we will not continue to discuss the issue. However, if there is sufficient interest, we will need to determine our next steps. We can't move without your input though. E-mail me with your feelings on the issue and keep in mind that changing the name may determine what direction the Caucus will move into in the future.

I know this is alot. I'm sorry it's so long, but I need your help and your ideas.

Have a wonderful week!
La Shae

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Subj: Conf minutes

Minutes/Update Minority Health Conference Planning Committee

This week, in addition to the regular conference planning meeting at 5pm on Tuesday in Rosenau 304, I met with Dean Small and Becky Hart of the Office of Continuing Education. The main points of that meeting are:
1. E-mail will be the major communication between committee members particularly for those who cannot attend the meetings.
2. Committee members who need to be working with the office of Continuing Ed will be announced via the e-mailed minutes.
3. October 20 the flyer announcing the conference is needed. October 27 the flyer is to go to the printer.
4. A copy of last years conference budget will be forwarded to Dean Small and myself.
5. Dean Smalls will attend our meetings when he can. 5pm is a difficult time for faculty and staff. I will continue to meet with him and the office of Continuing Education as needed.

Minutes of Oct. 10, planning committee meeting
Present: P. Alavarez, B. French, H. Straker

Conference title is Officially: Healthy People of Color 2000: Intervention Strategies.

Topic Areas and persons responsible for their objectives and contacting speakers are:
Migrant Health: Buffa French
Mental Health: Patricia Alvarez
Violence: Howard Straker
International Health: Buffa French
Community Based Prevention Programs: Sheryl Taylor
Substance Abuse: Philip Graham &/or Howard
Buffa will be sending out a memo to remind you.

Keynote Speakers the unofficial priority list is: Billie Avery, Reed Tuckson, Joycelyn Elders, Marian Wright Edelman, Helen Rodriquez-Trias, Casswell Evans.

We have agreed to have one keynote speaker. They will speak meet with caucus members Wednesday night and speak at the Thursday Luncheon. We want to have 2 additional speakers to open the conference each day. They should be dynamically motivational.

Buffa will place the tentative format/schedule for conference in your boxes this week. Please review it.

The poster sessions and student presentations should have a call for paper soon; possibly with the Conference flyer. Philip and Patricia should get together and talk with Becky Hart re: logistics around the poster sessions.

An idea for a job/career fair be added to the conference was raised. (similar to the one at APHA). Students would submit resumes and have a chance to be exposed to and interview with various agencies. The companies would pay to participate from their recruitment budgets. This would also expose students to internship/field placement possibilities as well as give companies and chance to see a cluster of candidates of color. Buffa will discuss the feasibility of pulling this off this year with both Dean Smalls and Becky Hart.

If you have any Ideas, criticisms and/or comments e-mail me at 40hstraker.

NEXT MEETING TUESDAY OCTOBER 17TH 5:00 PM ROSENAU 304.

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John Sharo
10/4/95

Minority Health Conference
Marketing Schedule

Activity	Completion Date
Flyer copy written and ready for layout (Includes title of program, theme, sponsors and purpose of the program)	October 20
Flyer to printer	October 27
Flyer received in field	Late November
Speakers confirmed, brochure copy written and ready for layout	November 10
Press releases sent to newspapers and journals	November 17
Brochure to printer	November 17
Brochures received in the field	Early December

John Sharo
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School of Public Health
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UNC at Chapel Hill

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February 8, 1996

Barbara Pullen-Smith, Director
Office of Minority Health
Dept. of Envr Hlth & Natural Resources
Raleigh, NC 27611-7687

Dear Ms. Pullen-Smith:

Thank you for agreeing to participate in the 18th Annual Minority Health Conference sponsored by the School of Public Health at the University of North Carolina at Chapel Hill. Entitled ***"Healthy People of Color 2000: Intervention Strategies"***, the Conference is scheduled for ***Thursday and Friday, February 15-16, 1996 at the William and Ida Friday Continuing Education Center.*** Your panel is scheduled for ***Thursday, February 15 from 9:15-10:15 a.m.*** You will be moderating the opening panel entitled "Health Status of the State/Nation: Where Are We Today and Where Might We Be Tomorrow?". The other panelists are Delton Atkinson, Director of the North Carolina State Center for Health Statistics and James Jones, Executive Director of North Carolina Healthcare Reform Commission. They will have 15-20 minutes for their presentations. After all of the panelists' presentations the floor will be opened to questions and discussion. As moderator, you will introduce the speakers and field questions from the floor. We also would like you to comment as you see fit from your perspective of the Office of Minority Health.

The School of Public Health will reimburse you for the cost of your travel expenses and meals. We hope you will join us for lunch at the Conference Center at 12:00 noon.

In order to process the paperwork to cover your expenses, we are requesting your ***social security number*** as soon as possible. We would also like to know what multimedia equipment you will need for your presentation, i.e. slide projector, overhead projector, videotape player, etc.

I am faxing this letter, the draft program for the Conference, and a copy of the latest news release for your review. I will send the originals to you via first class mail.

Thanks again for agreeing to do this for us in such short notice.

If you have any concerns please call me at ***(919) 914-5929 or Becky Hart of the Office of Continuing Education 966-4032.***

We look forward to having you with us.

Sincerely,

for Howard Straker
Conference Planning Committee

HS/rl
cc: William T. Small, Assoc. Dean for Students

Attachments

University of
North Carolina at
Chapel Hill

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UNC at Chapel Hill

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Tel 919-966-7676
Fax 919-966-6380

February 8, 1996

Delton Atkinson
State Center for Hlth & Envr Statistics
Dept. of Envr Hlth & Natural Resources
P.O. Box 29538
Raleigh, NC 27626-0538

Dear Mr. Atkinson:

Thank you for agreeing to participate in the 18th Annual Minority Health Conference sponsored by the School of Public Health at the University of North Carolina at Chapel Hill. Entitled ***"Healthy People of Color 2000: Intervention Strategies"***, the Conference is scheduled for ***Thursday and Friday, February 15-16, 1996 at the William and Ida Friday Continuing Education Center.*** Your panel is scheduled for ***Thursday, February 15 from 9:15-10:15 a.m.*** You will be part of the opening panel entitled "Health Status of the State/Nation: Where Are We Today and Where Might We Be Tomorrow?". We would like you to update the Conference on the status of People of Color in the state and nation in relation to the Healthy People 2000 Objectives. In particular we appreciate if you could highlight positive indicators that you may be aware of. You may also comment on strategies you think might improve the health status of Communities of Colors, the Healthy People 2000 Mid-Course Review and other indicators you think we should look at.

The other panelist is Dr. James Jones, Executive Director of North Carolina Healthcare Reform Commission. You both will have 15-20 minutes for your presentations. After all of the panelists' presentations the floor will be opened to questions and discussion. Ms. Barbara Pullen-Smith will be the moderator. As moderator she will introduce the panelists, field questions from the floor and offer comments.

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I am faxing this letter, the draft program for the Conference, and a copy of the latest news release for your review. I will send the originals to you via first class mail.

Thanks again for agreeing to do this for us in such short notice.

If you have any concerns please call me at ***(919) 914-5929 or Becky Hart of the Office of Continuing Education 966-4032.***

We look forward to having you with us.

Sincerely,

for Howard Straker
Conference Planning Committee

HS/rl

cc: William T. Small, Assoc. Dean for Students

Attachments

University of
North Carolina at
Chapel Hill

School of Public Health
sph
UNC at Chapel Hill

Office of the Dean
Rosenau Hall
Campus Box 7400
Chapel Hill, NC 27599-7400

Tel 919-966-7676
Fax 919-966-6380

February 8, 1996

Gary Grant
Executive Director
Concerned Citizens of Tillery
PO Box 61
Tillery, NC 27887

Dear Mr. Grant:

Thank you for agreeing to present at the 18th Annual Minority Health Conference sponsored by the School of Public Health at the University of North Carolina at Chapel Hill. *Entitled* ***"Healthy People of Color 2000: Intervention Strategies"***, the conference is scheduled for ***Thursday and Friday, February 15-16, 1995 at the William and Ida Friday Continuing Education Center.*** Your presentation is scheduled for ***Thursday, February 15 from 3:15 to 5:00 p.m.*** You will be part of panel discussing environment justice in North Carolina Communities of Color. We would like you to talk about the efforts of the Concerned Citizens of Tillery in addressing environmental issues like corporate hog farming. You will have approximately 20 minutes for your presentation. Following the panelists' presentations the floor will be opened for questions and discussion. The other panelists are Ron Nixon and Dolly Burwell.

The School of Public Health will reimburse you for the cost of your travel expenses and meals. We hope you will join us for lunch at the conference center at 12:00 noon, on Thursday prior to your presentation. We will also provide an honorarium of $125.00 as a small token of our gratitude for your participation.

In order to process the paperwork to cover your expenses, we are requesting your ***social security number*** as soon as possible. We would also like to know what multimedia equipment you will need for your presentation, i.e. slide projector, overhead projector, videotape player, etc.

I am faxing this letter, the draft program for the conference, and a copy of the latest news release for your review. I will send the originals to you via first class mail.

Thanks again for agreeing to do this for us in such short notice.

If you have any concerns please call me at ***(919) 914-5929 or Becky Hart of the Office of Continuing Education (919) 966-4032*** .

We look forward to having you with us.

Sincerely,

for Howard Straker
Conference Planning Committee

Attachment

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Chapel Hill, NC 27599-7400

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Fax 919-966-6380

February 7, 1996

Dolly Burwell
Registrar Deeds
Institute for Southern Studies
PO Box 254
Warrenton, NC 27589

Dear Ms. Burwell:

Thank you for agreeing to present at the 18th Annual Minority Health Conference sponsored by the School of Public Health at the University of North Carolina at Chapel Hill. *Entitled **"Healthy People of Color 2000: Intervention Strategies"***, the conference is scheduled for ***Thursday and Friday, February 15-16, 1995 at the William and Ida Friday Continuing Education Center.*** Your presentation is scheduled for ***Thursday, February 15 from 3:15 to 5:00 p.m.*** You will be part of panel discussing environment justice in North Carolina Communities of Color. We would like you to talk about landfill detoxification efforts in Warrenton. You will have approximately 20 minutes for your presentation. Following the panelists' presentations the floor will be opened for questions and discussion. The other panelists are Ron Nixon and Gary Grant, Tillery, NC.

The School of Public Health will reimburse you for the cost of your travel expenses and meals. We hope you will join us for lunch at the conference center at 12:00 noon, on Thursday prior to your presentation. We will also provide an honorarium of $125.00 as a small token of our gratitude for your participation.

In order to process the paperwork to cover your expenses, we are requesting your ***social security number*** as soon as possible. We would also like to know what multimedia equipment you will need for your presentation, i.e. slide projector, overhead projector, videotape player, etc.

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If you have any concerns please call me at ***(919) 914-5929 or Becky Hart of the Office of Continuing Education (919) 966-4032 .***

We look forward to having you with us.

Sincerely,

for Howard Straker
Conference Planning Committee

Attachment

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UNC at Chapel Hill

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Chapel Hill, NC 27599-7400

Tel 919-966-7676
Fax 919-966-6380

February 8, 1996

Ron Nixon
Associate Editor Southern Exposure
Institute for Southern Studies
PO Box 531
Durham, NC 27702

Dear Mr. Nixon:

Thank you for agreeing to present at the 18th Annual Minority Health Conference sponsored by the School of Public Health at the University of North Carolina at Chapel Hill. *Entitled "**Healthy People of Color 2000: Intervention Strategies**"*, the conference is scheduled for ***Thursday and Friday, February 15-16, 1995 at the William and Ida Friday Continuing Education Center.*** Your presentation is scheduled for ***Thursday, February 15 from 3:15 to 5:00 p.m.*** You will be part of panel discussing environment justice in North Carolina Communities of Color. We would like you to talk about the efforts of the Investigation Action Fund in addressing environmental issues like corporate hog farming. You will have approximately 20 minutes for your presentation. Following the panelists' presentations the floor will be opened for questions and discussion. The other panelists are Gary Grant, Tillery, NC and Dolly Burwell, Warrenton, NC.

The School of Public Health will reimburse you for the cost of your travel expenses and meals. We hope you will join us for lunch at the conference center at 12:00 noon, on Thursday prior to your presentation. We will also provide an honorarium of $125.00 as a small token of our gratitude for your participation.

In order to process the paperwork to cover your expenses, we are requesting your ***social security number*** as soon as possible. We would also like to know what multimedia equipment you will need for your presentation, i.e. slide projector, overhead projector, videotape player, etc.

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Sincerely,

for Howard Straker
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Chapel Hill