S. HRG. 103–653

SOCIAL PROBLEMS AND HEALTH CARE COSTS

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED THIRD CONGRESS

FIRST SESSION

OCTOBER 19, 1993

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE
78–661—CC WASHINGTON : 1994

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-044727-5

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SOCIAL PROBLEMS AND HEALTH CARE COSTS

TUESDAY, OCTOBER 19, 1993

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:08 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Daniel Patrick Moynihan (chairman of the committee) presiding.

Present: Senators Bradley, Pryor, Riegle, Rockefeller, Daschle, Chafee, Durenberger, and Grassley.

[The press release announcing the hearing follows:]

[Press Release No. H–39, October 13, 1993]

FINANCE COMMITTEE TO HOLD HEARING ON THE CONSEQUENCES OF SOCIAL BEHAVIOR ON HEALTH CARE; FORMER SECRETARY LOUIS SULLIVAN TO TESTIFY

WASHINGTON, DC—Senator Daniel Patrick Moynihan (D–NY), Chairman of the Senate Committee on Finance, announced today that the Committee will conduct the third in a series of hearings on topics related to health care reform. Next week's hearing will examine the impact of social behavior on health care in America. Witnesses will include former Health and Human Services Secretary Louis W. Sullivan.

The hearing will begin at *10:00 a.m. on Tuesday, October 19, 1993,* in room SD–215 of the Dirksen Senate Office Building.

"The social pathologies of our time—violent crime, the break-up of the family, and others—have an effect on nearly everything, but certainly on health care," Moynihan said in announcing the hearing. "Can we measure this effect? What does it cost us, in lives, money, and health? Perhaps we can find out."

OPENING STATEMENT OF HON. DANIEL PATRICK MOYNIHAN, A U.S. SENATOR FROM NEW YORK, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. A very good morning to our most distinguished guests and witnesses. This is another of a series of hearings of the Committee on Finance on aspects of health care in our country as we prepare for the President to send us his bill, and we have other legislation coming along as well. We will be spending almost all of our time on this subject in the remainder of this year and the year to come.

I have a brief opening statement, for which I would ask the indulgence of the Senators and Dr. Sullivan who has so very generously come to appear before us.

Our hearing today is on the subject of social behavior and health care costs. We are hugely honored that Dr. Sullivan could come to speak to us because, as Secretary of Health and Human Services, he emphasized this so very much, appropriately, and about time.

For some months now the committee has been holding hearings on aspects of health care costs which seem to call for special attention or, to put it another way, are not receiving enough attention.

We noted, for example, that Medicaid if expenditures, which are associated with poor families, continue to grow at the same rate as that of the 8 years of the Reagan administration, followed by the 4 years of the Bush administration, on December 29, 1996 they will double in 1 day, such is the power of a geometric equation, the power of compounding rates once they are in place.

This morning we are going to address, among other things, the relationship between health care costs and other social problems. We have asked our witnesses to address the steady rise in the ratio, and to some extent the rate, of births to unmarried women. The ratio was 5 percent 50 years ago.

As was noted at the time, it began to rise in the 1960's. It reached 10 percent in 1970. Since 1970 the rise has been a virtually straight line and has now reached 30 percent.

The correlation between the observed values and a trend rising at almost 1 percent a year—.86 percent—is 0.991. I do not believe there is such a correlation in social statistics. The correlation between birth and death is higher. [Laughter.]

But just somewhat.

This suggests the possibility that by the year 2016 the ratio will be 50 percent. In testimony prepared for this morning's hearing Dr. Lee Rainwater suggests that it will surely, and I quote, "rise toward 40 percent by the end of the century." The ratios are much higher in cities.

Senator Riegle has to chair a mark-up, but he will be here shortly. Detroit has reached 71 percent of all births. The Houston ratio of 26 is probably accounted for by the singularly large area within the city boundaries. Houston runs to the Rio Grande practically. The San Francisco ratio of 31 percent is probably accounted for by a relatively large Asian population, which has a lower overall ratio. Otherwise, the situation is much the same everywhere, devastating in its implications generally, health care costs being the least of it.

May I just say that one of the depressing aspects of this demographic transformation, where it surely is such, is that so far as we can tell no one in the vast health bureaucracy of the Federal Government seems to have noticed it—this correlation. This does not give confidence that the subject will be seriously addressed in the forthcoming health care legislation.

One asks then, can this trend be stopped or reversed. I do not know, but we had better ask. I am scarcely alone in this regard.

On September 19 this year, on Meet the Press, Mr. William Raspberry of The Washington Post said that the thing we call civilization is rather a thin veneer. We are discovering through almost inadvertence that one of the ways of preserving that civilization, that civility, is the thing that human beings happened upon a few millennia ago—that is, two-parent families, it works.

I was on the same program and agreed. This past Sunday, Reverend Jesse L. Jackson was on Meet the Press, the same program, and asked if he thought we were right. He replied, "No doubt about it."

He then used a phrase which I think is very important—he said, "What was a problem has now become a condition."

In his testimony this morning, Dr. Reynolds Farley states that, "Shifts and attitudes imply that our norms may no longer abjure childbearing by unmarried women, despite the deprivation that follows for so many children."

That is the subject we are going to address this morning. It involves us all. I am going to turn, as is our practice, to the Senator from Arkansas, who was the first to arrive at the hearing.

OPENING STATEMENT OF HON. DAVID PRYOR, A U.S. SENATOR FROM ARKANSAS

Senator PRYOR. Mr. Chairman, thank you. I really do not know that I have anything that is all that totally relevant to the subject at hand, to the title of today's hearing.

But I would like to say as a close kin, I guess, or certainly within the parameters of kinship to the issue at hand today, Mr. Chairman, I have recently sent two outstanding members of our staff down to Little Rock to meet with police officials, the Pulaski County coroner—where Little Rock is the county seat—to talk to school administrators, to public health workers, and others right down the line.

They came back after the Columbus Day recess and not only prepared me somewhat of a brief of their findings and their interviews, they also had the opportunity of spending considerable time with one of the gangs.

When we think about gangs, often times we think about gangs in your State of New York. Little Rock, AK has every gang that you have, sir, in New York.

One reason for this is that we are at the crossroads of east and west and north and south. We get all the gangs from Los Angles, Chicago, and Washington.

The CHAIRMAN. Los Angles?

Senator PRYOR. We are right in the center. And as a result, we find today that surprisingly Little Rock, AK has perhaps the highest homicide rate among juveniles of any community in the United States.

This is a problem we do not know what to do about. Certainly we do not know how to pay for all of this violence. We are looking at violence in the context of universal health care, and we do not know what the price tag is going to be. I have seen some figures that a shooting, for example, costs us ultimately some $300,000, uninsured usually. Of course, I have never heard of anyone being victimized or actually doing the shooting who had any insurance of any sort.

But all of this relates, I think, Mr. Chairman, to the social fabric issues you have been talking about for now about 3 decades. I certainly want to compliment you for it.

One of the things that relates to the family was something that our two staff members picked up as they had an extended visit with one of these gangs in Little Rock the other afternoon. One, the gang sent out guards. They put guards up in the trees so other gangs could not see them talking to our staff.

Second, they had a young man 7 years old. They bought him a bicycle and a telephone. And when he sees, as he drives his little bicycle through the neighborhood, a 7 year old, he presses *–1, that rings into headquarters, and he tells the superiors where the police officers are at any given time—7 years old. And they pay him $50 a day. They buy a bicycle for him and give him a telephone.

Then they ask a question. I think this sums the whole thing up and this is where Dr. Sullivan, I think, and all of us have really got to zero in. The said, "What does your family think about you belonging to this gang," and the gang members said, "Our family? This is our family. The gang is our family and that is all the family we have." They are 13, and 14, and 15 years of age.

Police officers are bound by the fact that they cannot arrest many of these individuals because they fall under the juvenile statute. That is a whole other issue. They are smart enough not to carry guns around with them, Mr. Chairman and Dr. Sullivan. They have them stashed out. They have them buried here and hidden in a tree trunk here and whatever. But they are never very far from their cash, I guess you would say, of guns and weapons of all sorts.

So what I am saying is, this is not an urban problem only. This is in rural America. It is in Iowa, Senator Grassley. It is throughout our smaller towns in Arkansas today and becoming more and more evident.

I was just looking at these figures. I am not going to take much longer, Mr. Chairman, because I want to hear Dr. Sullivan and our other witnesses. But from 1990 to 1992 in Pulaski County, Arkansas, there were 69 juvenile arrests for murder. From 1984 to 1990, there were only 8 juvenile arrests for murder.

So we see there in a 6-year period, we see a tremendous explosion of juvenile murders and homicides. Here are the people in the Pulaski County, individuals age 13 to 23, who in 1992, 38 of them who were murdered—from 13 to 23. Probably 85 percent of these were gang related. This is in Arkansas, a small-world State.

I might add that I think all but about four of these were black males who were murdered. I do not want to talk about race. I just want to state the facts. I think we have got to deal with this. I hope that from the President down through, Democrats and Republicans, conservatives and liberals, that we are really looking at this problem and what we can do about it, or it is going to be too late. It is going to be too late as some of the figures you have brought to our attention have demonstrated.

But I am ready and willing. I think we have to do something. There are so many facets to this problem—our welfare system, our educational system, health care, what it is costing, the crime problem, the gun problem. We are going to have to do something about handguns. We cannot hide behind that anymore. I know the NRA does not like that, but we are going to have to do something.

And we are going to have to do something about assault weapons because these people practice respect and then they want—they need the respect of their peers first I understand, and then retaliation, and then revenge. This is an ongoing cycle that we must eliminate if our society is going to survive.

Mr. Chairman, I thank you for this hearing.

The CHAIRMAN. We thank you, sir.

Senator PRYOR. I have a statement I would like to place in the record.

The CHAIRMAN. We will place it in the record.

[The prepared statement of Senator Pryor appears in the appendix.]

The CHAIRMAN. That could not have been more powerful. I believe one of the staff members who was visiting with one of those gangs is here today.

Senator PRYOR. Steve Glaze. Mr. Mike Hodson, the other staff member, I believe he is still afraid to go out the front door. [Laughter.]

Both of them did a very superior job.

The CHAIRMAN. Senator Grassley?

OPENING STATEMENT OF HON. CHARLES E. GRASSLEY, A U.S. SENATOR FROM IOWA

Senator GRASSLEY. Thank you, Mr. Chairman; and welcome, Secretary Sullivan. I am very grateful that you have decided to devote an entire hearing to the relationship between social problems and health care costs.

I have been interested in this relationship for some time since I requested that the Office of Technology Assessment incorporate a focus on social problems into its study of international health statistics. That study, I think, will be ready soon and I am looking forward to what it has to say on the subject.

This hearing will remind us that it is very important to keep clear the distinction between the health care system and our surrounding society. In too much of our debate about the American health care system, it does not seem to me that we do this enough. This is nowhere more evident or more annoying than when we fool around with generalizations that supposedly compare the quality of the American health care system with the quality of foreign health care systems.

In the first place, as I think this hearing will show, much of our high health care costs comes from social problems. Maybe we should even call these social pathology. These have absolutely nothing to do with the health care system. I am talking about substance abuse, AIDS, other sexually transmitted diseases, violence, accidents, and adolescent teen pregnancy.

In the second place, many of these generalizations about how much better health care other societies get from what they spend on health care are not very helpful and are probably next to meaningless.

The reason is that they are usually based on health status indicators. And as the Office of Technology Assessment Report that I mentioned earlier will say, health status indicators are useful as social indicators, but "are not by themselves useful measures of the success or failure of a country's health care system."

So, Mr. Chairman, I think we need to ponder the implications of these points because we still have the so-what question. I mean, once we acknowledge that social problems contribute to the high costs of health care, what do we do about it; and what does that mean for a health care reform debate.

I certainly do not have an answer to the so-what question. The answer, if there is one, will emerge out of the health care reform debate.

I thank the chairman for this hearing because if anyone—meaning you, Mr. Chairman—can help us come to grips with this problem, it is you, because you have given a great deal of attention over the past 30 years to these important issues.

I want to conclude with two or three responses to the so-what question. In the first place, maybe instead of doing so much worse than other countries, as all of this talk seems to imply or assert, our health care system is doing better than these other systems in some important respects and maybe a lot better in some. Maybe we are not doing as well, however, as a society.

Maybe we are going to be very disappointed after tearing our health care system apart and putting it back together, meaning reforming it, to find that we still have high health care costs because that reform will have absolutely no influence on the kinds of behavior that we are talking about here. Maybe we need to be focusing on other policy areas in addition to health care—like welfare policy, jobs policy, family policy, just as for instance.

Then again, maybe there is nothing government can do to eliminate or reduce these social pathologies. Maybe we need to think hard about how the health consequences of these social pathologies are going to be cared for in a reformed and community-related health care system. Some writers have already begun reminding us that the formation of health alliances is going to have some very big implications for who ends up paying the costs of these social pathologies.

But I hope that this committee does not let this subject drop as we go forward with our discussion of health care reform. I yield.

[The prepared statement of Senator Grassley appears in the appendix.]

The CHAIRMAN. We thank you very much, sir. You are never going to get the right answers until you ask the right questions. Are you? I think you were doing just that. But we look forward to that OTA report.

Senator Daschle?

OPENING STATEMENT OF HON. THOMAS A. DASCHLE, A U.S. SENATOR FROM SOUTH DAKOTA

Senator DASCHLE. Thank you, Mr. Chairman. Let me commend you for yet another in a series of very valuable hearings as we consider a number of aspects of health care and the costs of health care in our country today.

I think that this one may be the most troubling because in some respects it is the most complex, and not strictly addressed through government programs. No one knows that better than our chairman.

Of all of the aspects that interests me, I think, with the possible exception of violence, substance abuse is the most compelling. It is a social problem with immense health care cost consequences. I do not know that anyone can truly appreciate or accurately estimate the immensity of that cost.

I was interested in a couple of charts recently provided for us—one by the Substance Abuse and Mental Health Services Administration, which was once called the Alcohol, Drug Abuse, and Mental Health Administration. They estimate the cost of substance abuse in the United States each year to be $144 billion, including $40 billion in lost productivity and $56 billion in crime; in addition, of course, to the $47.9 billion in health costs.

Whether it is $144 billion or something even greater, we recognize the extraordinary cost to society and are only beginning to realize its ramifications.

Of particular interest to me is the effect of alcohol on society. We have extraordinary numbers of victims of fetal alcohol syndrome. It is estimated to be as high as one in ten on Indian reservations.

But regardless of cost, the most troubling aspect of fetal alcohol syndrome is that it is 100 percent preventable. It is one of those few mental diseases that can be prevented. Yet it is the single largest cause of mental retardation in the United States today.

The University of California estimates the cost over the course of a year at $1.6 billion, just in fetal alcohol syndrome related costs alone. This is an extraordinary cost to the health system and obviously a devastating cost to society, especially certain segments of society.

As we consider substance abuse, I hope that fetal alcohol syndrome will be better understood. I also hope we might find ways in which to deal with it more effectively as we begin to reform health care.

With that, Mr. Chairman, thank you.

The CHAIRMAN. Well, thank you. Thank you, Senator Daschle. That is devastating.

Finally, Senator Durenberger, we welcome you.

OPENING STATEMENT OF HON. DAVE DURENBERGER, A U.S. SENATOR FROM MINNESOTA

Senator DURENBERGER. Mr. Chairman, thank you. I do not have an opening statement. You and I have discussed this particular subject.

The CHAIRMAN. We have been talking about this.

Senator DURENBERGER. I am so grateful to you for broadening the definition of health and for selecting Lou Sullivan, who is our friend, to be the first witness of the panel.

I just need to remind all of us that at his nomination hearing 4 years ago or whatever it was now, four plus years ago, our dear beloved colleague, John Heinz, asked Dr. Sullivan, what do you want to be remembered for. His answer was very simple, very straightforward. He said, I want to be remembered as a person who has helped Americans to think differently about health, and about their responsibility for their own health, and about our responsibility as a nation and as people in the public policy area to get us all to think differently about this whole subject of health care.

I compliment him for his record as Secretary in doing that, and for committing a good part of his post-political life to doing the same thing.

The CHAIRMAN. Thank you, Senator Durenberger. I would like to suggest that Secretary Sullivan is remembered for that, and he will

continue to be; and also will be remembered for something else. Having been one of the most distinguished members of the Cabinet of a very successful President, instead of setting up shop on K Street, he went back to his medical school, which is, I think, maybe a first.

Fortunately, he does get to Washington. He came for this purpose. We welcome you, sir. Would you proceed exactly as you wish. We have your statement, of course.

STATEMENT OF HON. LOUIS W. SULLIVAN, M.D., SECRETARY OF HEALTH AND HUMAN SERVICES (1989–1993), AND PRESIDENT, MOREHOUSE SCHOOL OF MEDICINE, ATLANTA, GA

Dr. SULLIVAN. Thank you very much, Mr. Chairman and members of the committee. It is a great pleasure and honor to have this opportunity to appear before you today.

Our common mutuality is nowhere more evident than in health care, where our individual actions can affect many others throughout their lives.

Mr. Chairman, we must assist our citizens to better visualize the impact of particular unhealthy actions. For example, the decision to smoke is responsible for one of every six deaths in America. That comes to 435,000 deaths every year or 1,200 deaths a day.

Furthermore, smoking costs our country some $65 billion annually in health care costs. This represents a hidden tax of $221 on each and every American. A recent study by the Columbia University Center on Addiction and Drug Abuse, headed by former Secretary Califano, has found that $2 billion of Medicaid hospital expenditures in 1991 was a result of tobacco use.

The decision to abuse alcohol or use other drugs is also costly. Violence, crime, unemployment and other social problems have been linked to elicit drug use. There are also economic costs. The annual costs for alcohol and drug abuse are between $100 and $200 billion.

Mr. Chairman, each year there are more than a half million Americans who die from coronary artery disease, and the annual economic costs of this disease is well over $100 billion.

By emphasizing better health practices through early education and public information campaigns there was almost a 30 percent reduction in age-adjusted death rates due to heart attacks in the United States than the period 1978 to 1988—30 percent reduction.

Through healthier lifestyles and the appropriate use of medications and other actions, a further 60 to 80 percent reduction may be possible, with great cost savings for the nation. And we know from a growing volume of studies that family disintegration, dropping out of high school, teen pregnancy, poverty, poor health status, disability and premature death are all interrelated, even intergenerational, as shown by you, Mr. Chairman, in your writings.

As a power-walker, I am also aware of studies that show that exercise, especially brisk walking, has positive results in later life.

The CHAIRMAN. Mr. Secretary, it is just a terminological problem. We know about power brokers here, but what about power-walkers? What is a power-walker?

Dr. SULLIVAN. Yes, Mr. Chairman, this is an exercise that I engage in with my wife every morning. We walk some 3 miles in about 45 minutes. That is a fairly brisk pace.

We started this some 17 years ago, primarily as a weight reduction strategy. But we certainly know from many studies that individuals who are physically active, that is 3 or more days a week for 30 minutes or more, have a number of benefits.

First of all, they have a lower rate of heart attack, of stroke. If they have high blood pressure, their blood pressure tends to come down and may come down far enough that no medication is required. If they are diabetic, their diabetes is more readily controlled. It also helps prevent osteoporosis, helps keep the bones strong.

Most strikingly, studies have now shown that people who are physically active actually live longer. So in contrast to the situation of some 20 years ago when this was all dismissed as simply a fad, we have now data from a number of studies that show the benefits from this.

So certainly this should be part of any health promotion disease prevention campaign. So power-walking is simply one form of exercise—brisk walks, with a lot of swinging of arms, et cetera. It is great fun and I recommend it.

Senator DURENBERGER. Mr. Chairman?

The CHAIRMAN. Sir?

Senator DURENBERGER. If I might just add a dimension, and I do not know who is listening to this or might benefit from this, but my father was an athletic director in a small college and he could tell as I was growing up I was not going to be a great athlete. He was concerned about the same sort of things that Lou Sullivan is concerned about, which is overweight and/or the heart and so forth.

He suggested to me, I used to have to walk to school every day, about a mile, and then a mile home and so forth. He said, when you are walking, take an extra 6 inches in your steps. Just think about it in that context. Try to take an extra 6 inches in your steps.

Well, I grew up to be fairly tall, long legs, and an extra 6 inches means nobody on my staff can ever keep up with me. [Laughter.]

But I must say, here I am almost on the verge of 60, and while I am not a good physical specimen, I think there are various ways in which Americans in one way or another can practice without a lot of going into the gym sort of activity, can practice some kind of physical exercise.

The CHAIRMAN. Good advice. Thank you all.

Dr. SULLIVAN. If I might add, Mr. Chairman, to this, one of the striking things is this, that only about 30 percent of Americans, including teenagers, have such a program of regular physical activity. So we really fall far short of what we should be doing there. And walking, of course, is the simplest kind of exercise. It does not require any kind of special equipment.

I certainly recommend it and I have walked in virtually every major city in the country and many cities around the world. It helps you to get to know your environment as well. So I certainly recommend it as a very easy exercise. Everyone should really do it.

Senator PRYOR. Well, I do not want to interrupt. But what if you are afraid you are going to get killed on your walk? [Laughter.]

Senator DURENBERGER. That is why we are here today.

Senator PRYOR. That is why we are here. My doctor the other day said, you have to make certain that every evening after dinner you go out and have a walk. I said, I would not do it for the world. I would be murdered.

The other morning I was asked in a school I was speaking to in Arkansas, what is your greatest fear about your job; and I said it is Monday and Thursday nights. And they said why. I said it is the night I take my trash out on the sidewalk and I am afraid I will get murdered out there. [Laughter.]

I am not making light of this. I think walking is great exercise and I am glad you do.

Dr. SULLIVAN. I agree with your concern, Senator Pryor. That really, I think, is a marker for the difficulty our society has.

Clearly, we have a situation now that was virtually unheard of when I was growing up—the real threat to life and limb that citizens have just in their own neighborhoods.

Well, each mile that a person walks gives him or her approximately 21 extra minutes of life and saves our society some 24 cents in external costs. Conversely, our society pays around $1,650 in life time medical and other costs for each person who does not exercise. These are but a few examples that document a link between behavior and health.

But, Mr. Chairman, there are many people who remain unconvinced of the value of health promotion, disease prevention efforts. We will never have meaningful, coherent, constructive, effective health care reform without a strong, vigorous and credible prevention effort. We will need this on a wide range of fronts.

Reform is not merely about passing laws in Washington or in our States. Reform is not simply adjusting the financing or the delivery of medical care. Comprehensive national reform must include each and every American. It must include our families, our corporations, indeed, all of our institutions, public and private.

Our citizens must be persuaded to make a personal and cultural transformation to achieve better health status. Mr. Chairman, we have now a singular, unique, unprecedented moment in history to explain these relationships and to empower our citizens to become part of the health care solution through the individual decisions they make.

Translated into strategies that would mean healthier, longer lives for our citizens. We must work to help people stop smoking, to end alcohol misuse, to eliminate drug use, to avoid the high-risk behavior that spreads the AIDS virus, to seek early prenatal care during pregnancy, to improve our eating habits, to wear seatbelts in our vehicles, to increase exercise, to resolve conflicts among us without resort to violence, and seek necessary medical examinations and vaccinations for our children.

By improving our health behavior, we could eliminate 45 percent of deaths from cardiovascular disease, 23 percent of deaths from cancer and more than 50 percent of the disabling complications of diabetes. In fact, control of fewer than ten risk factors could prevent between 40 to 70 percent of all premature deaths in our soci-

ety. We could reduce by one-third all cases of acute disability; and we could reduce by two-thirds all cases of chronic disability.

Mr. Chairman, we must also make greater efforts to reach out to our poor and our minority communities. There are more than 73,000 excess deaths each year in our Nation in our minority communities. And while the health of the population in general has improved each year, and it was my pleasure as Secretary to announce these improvements, in contrast, black health status has not improved over the past decade.

Recent studies in the New England Journal reported that the gap in health status between rich and poor over the last 25 years has actually widened and inequality that is fueled by a growing disparity and mortality between Black Americans and White Americans.

These studies further documented that our poorest citizens are least likely to have good health status. We must make our health care system more culturally sensitive and user friendly for our poor and our minority communities. That includes more credible and comprehensive programs.

Prevention programs are virtually nonexistent in many urban and rural areas. And when available, many prevention programs have little credibility or they are viewed with suspicion or misunderstanding. We must offer a straightforward, believable message that motivates behavior change, without alienating our citizens, what much of the government can do to help our citizens, help them to empower themselves.

You may recall, as Senator Durenberger noted, in my hearings before this very committee some 4½ years ago, I pledged to make prevention a high priority during my tenure. So I was pleased that during my time in office we released Health People 2000, a blueprint of our Nation's health objectives for this decade; and a powerful plan for greater health promotion/disease prevention efforts.

We also reorganized the Department of Health and Human Services, creating the Administration for Children and Families to make our programs more effective in strengthening our families. Initiatives in food labeling were designed to empower our citizens to make better informed choices about their diet. We also use a bully pulpit of public office to inform our citizens, such as in my anti-smoking campaign launched in January of 1990.

We also stated that violence is a public health problem and we must address the causes of violence while the criminal justice system confronts its effects. I was very supportive of a strong energetic office of minority health at the Department of Health and Human Services, an office that is an essential ingredient in any credible prevention campaign for our minority communities.

We must build on this legacy. The public sector must explore other efforts to help our citizens protect their health through their daily decisions. The private sector should also get involved. For example, we need more of our physicians to be primary care practitioners.

Primary care physicians help to educate and inform our citizens about avenues to better health. I am proud of the fact that the Association of American Medical Colleges has found that Morehouse School of Medicine, my institution, is now the number one medical

school in the nation in the percentage of its graduates practicing as primary care physicians.

In addition, the Morehouse School of Medicine has among its community outreach programs a health promotion/disease prevention resource center.

Philanthropic organizations can also provide people- oriented training and prevention programs, such as efforts by the Kellogg Foundation for primary care community partnerships, and the Robert Wood Johnson Foundation's Primary Care Training Initiative. We need to expand such programs to effectively address the national need for more primary care physicians, and the need for improved health behavior by our citizens.

Mr. Chairman, we must do nothing less than create a culture of character—a greater sense of personal responsibility and community service. To succeed in this, we must enlist the leadership and support of our churches, our schools, our community leaders and our associations, and other value-generating institutions of our society.

As we reform the health care system from within, we must also ask our citizens to reform it from without. The American people themselves can become agents of change, the vanguard of a new health consciousness that will lead to improved health status, a stronger sense of community, and more efficient use of our health care resources.

Again, thank you for this opportunity to appear before you. Thank you.

[The prepared statement of Dr. Sullivan appears in the appendix.]

The CHAIRMAN. Dr. Sullivan, it is just a joy to see you back. And that bully pulpit seems to have never deserted you.

I would like to have just one question, which seems to me so important. When you were Secretary, you stated that "violence is a public health problem." I noticed that the Centers for Disease Controls in Atlanta is beginning to think about the epidemiology of the issue. I am rather tedious with my colleagues on this committee, stating, for example, that guns do not kill people; bullets kill people.

The bullet is the pathogen and an epidemiologist would start looking for that factor. But surely there is an association with the decline of social structure of the sort we see in Atlanta, which is as it happens, one of the 20 largest cities in the nation—where 64.4 percent of the children born are to unmarried women.

Surely we have established a relationship between the socialization of males in such systems and violence, teenage violence, have we not? The kind of socialization that Senator Pryor described so graphically when he said, "what does your family think," and these teenagers say, "well, this is our family."

Dr. SULLIVAN. Yes, Mr. Chairman. First of all, let me say that I was pleased with the appointment of Dr. David Thatcher to be the new head of the Centers for Disease Control, who has emphasized that the study of violence as a public health problem will be a major priority of his tenure.

This is a serious problem in our society and must be addressed. As you know, these problems are all interrelated. The fact is that

presently one of every two marriages in our country ends in divorce; and we know that children who grow in single-parent families, in spite of the heroic efforts of many mothers heading these families, these children are five times more likely to be poor. They are twice as likely to drop out of high school to become teen parents themselves. They have a 20 to 40 percent greater evidence of anti-social behavior.

So, clearly, all of these things are contributing to this problem.

The CHAIRMAN. There is the incidence of, as you say, anti-social behavior that is pretty well established now, is it not?

Dr. SULLIVAN. Yes.

The CHAIRMAN. A clinical proposition. You would teach it.

Dr. SULLIVAN. Yes, very definitely. We clearly here have young people growing up without the benefit in most instances of a father as a mentor role model, helping young men during their development years learn how to control passion and how to socialize in a constructive, effective way.

The CHAIRMAN. How to handle aggression.

Dr. SULLIVAN. Yes. The other point I would make, Mr. Chairman, in my comment about violence being a public health problem is this: We know that with the tragic number of homicides in our country each year, more than half of these are homicides where the individuals knew each other—the victim as well as the one who is committing the homicide. Frequently they are relatives or friends, individuals who may have been drinking together or what have you.

What we need to understand more clearly is, what are those antecedent or associated factors. If we can learn more about that, perhaps we can find ways to prevent this. We can know when there is a greater risk than at other times.

So this is a problem that we believe will be susceptible to analysis as a public health model.

The CHAIRMAN. I do not want to continue. Others are here. But it would be my bet that the proposition that 50 percent of homicides involve persons who know each other is a historical low. In fact, it was 80 percent 40 years ago. It speaks to a difference as such. Thank you.

Senator Pryor?

Senator PRYOR. Thank you, Mr. Chairman.

Dr. Sullivan, when our staff members were out having the interview, I guess you would call it, with one of the gangs in Little Rock, our staff member asked the question, how many of you live with your mother and dad. There were 12 in this particular session of the gang members. Of the 12, zero lived with their mother and dad.

The CHAIRMAN. Zero?

Senator PRYOR. Only half lived with one of the parents. Six lived with either, usually the mother; and some lived with a grandmother or aunt.

Then we come back to the issue, Mr. Chairman, of does the welfare system discourage marriage. Some say that it does and some say no. But do you have a comment on this aspect of our welfare system?

Dr. SULLIVAN. Yes, Mr. Pryor. Let me say this: In those States where indeed individuals are not allowed to accumulate savings to try and better themselves of their families, and that includes indeed where they lose their benefits if there is a male in the house, I think it very definitely is a system that works against formation of families.

It was my pleasure during my time as Secretary to indeed approve some represents. I remember particularly the State of Wisconsin proposed a pilot study to allow teen parents, to allow young teen male parents to indeed live with the mother of their children and without loss of benefits. In fact, the program, all of the details I do not remember, but part of the program was to provide job training for those parents as well as to continue Medicaid benefits.

So clearly in a number of States where loss of eligibility occurs if there is a male in the house, I think it does discourage a marriage. We want to, I believe, do just the opposite. We want to encourage families to stay together. It will be good for the children, as well as for that family in the long run.

Because basically, as you know, the family is our basic societal institution. When our families are in trouble, it means our society is in trouble.

Senator PRYOR. Thank you, Dr. Sullivan.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, sir.

Senator Grassley?

Senator GRASSLEY. Mr. Chairman, there is nothing unimportant about the subjects we are discussing this morning.

They are a cost of the system. They are something we have to worry about. So it leads me to think that if those costs are still going to be out there, and we were spending as much time trying to solve those problems as we are putting political capital into health care reform, we might really be doing something about the costs of health care.

Because, you know, we spend all of our time looking internally. We argue that it is these internal things that are making the costs of health care go up. Things like fee-for-service together with third party payment. Things like the venality of health care practitioners or administrative waste.

These are the things that we are concentrating on, that we have identified, that are costly to the system. But we could miraculously take care of these problems; and then we would still have the costs from teenage pregnancy, and from drug abuse, and from AIDS, et cetera, et cetera.

Maybe it is impossible for you to answer this question. But is it possible to say what portion of total health care costs are caused by the accumulative affect of these kinds of behaviors in the United States that I call social pathology? As far as I can tell, most of our analysis of health care cost problems focus on those internal things that I have referred to. I will not repeat them.

This leads to the conclusion that radical reform of the system is called for. But what if most of the cost problems is to be traced to the social pathology dimensions? It seems to me that that would make us look primarily to other policies that have an influence on health care cost increases.

Can you comment on the question of whether most of the costs come from social problems as contrasted from within the health care system, like administrative waste and unnecessary care, in part generated by the fee-for-service system, third party payers, et cetera? Are there some policies that would be more strategic and more key to achieving reduced health care costs in your view?

Dr. SULLIVAN. Thank you, Senator Grassley. Let me say that you make a number of very important points. Let me say first of all, the percentage of our health care expenditure that is perhaps behaviorally related, I really cannot say, but I can say with confidence, it is a very high percentage. So I would say easily 35 to 50 percent or perhaps even higher.

The CHAIRMAN. You put a number on it.

Dr. SULLIVAN. Yes.

The CHAIRMAN. Say a third to a half.

Dr. SULLIVAN. Yes. Let me point out for you some specific examples. In November of 1991 I spent 2 weeks in Japan as a guest of the Minister of Health there. As you know, Japan is often cited as one of those countries that spends less per capital on health care and has better health status than we do. Both of those are true.

But in the country of Japan with 135 million people, there are fewer homicides than in the City of Washington, DC. And, indeed, I agree with you——

Senator PRYOR. Just a moment. Say that again, please.

Dr. SULLIVAN. There are more homicides in Washington, DC in 1 year than in the entire country of Japan—135 million people.

The point is, these murders, as well as these injuries, are from handguns that, indeed, get funneled into our health care system and do result in major costs. I think you mentioned a $300,000 figure. So that is one burden that is borne by the health care system.

Let me also point out that in the United States 70 percent of pregnant mothers receive prenatal care in the first trimester of pregnancy, come in for care. In Japan that is 98 percent. And, of course, Japan has the lowest infant mortality rate in the world.

So there is a clear relationship between early prenatal care and outcome of pregnancy—lower infant mortality, lower incidence of low birth weight babies and other problems there.

The CHAIRMAN. And you would also associate that with births to unmarried mothers as against married mothers?

Dr. SULLIVAN. Yes.

The CHAIRMAN. Prenatal care.

Dr. SULLIVAN. Very definitely, yes. And as I mentioned earlier, just the simple thing with physical activity, we are a nation of couch potatoes, where 30 percent of our teenagers—only 30 percent have a regular program of physical activity.

So in other words, we have a number of behavioral indices that, indeed, result in illness or injury and that gets loaded into the health care system.

I was interested, for example, during my tenure as Secretary at looking at seat belt usage among our 50 States. It ranked from as high as I think something like 80 percent of people in Hawaii who wore seat belts, but as low as 17 percent in Mississippi.

When those people not wearing seat belts in an injury that throws them from their automobile and they end up with a cracked

skull or a fractured spine, that gets into our health care system loaded up as tremendous costs. So, indeed, there are many savings that can occur in our health care system by behavior change.

But even more important than that really is the disability, the mortality, and all of the grief that results from that.

Let me just point out one final point, Mr. Chairman. This past Sunday the New York Times had a very good article citing the fact by many public health officials that indeed if we only reform the health care system, i.e. change how we deliver——

The CHAIRMAN. The cost. If we only reform the cost.

Dr. SULLIVAN. Exactly. That we have to look at behavior. If we simply reorganize how we give care and pay for it, we still are not going to bring health care costs under control. And also, we are not going to improve the health status of our citizens.

The CHAIRMAN. That is a very fine point.

Senator GRASSLEY. That was exactly the point that I was trying to make.

The CHAIRMAN. That's the point you were making, Senator. Exactly.

Just a quick thing. There are so many feedbacks in these matters. But 40 years ago we could demonstrate that the use of seat belts was powerfully correlated with the number of years of schooling. You know, people with 2 years of graduate work had enough sense to put seat belts on. It is as simple as that.

Senator Daschle?

Senator DASCHLE. Dr. Sullivan, I certainly would want to emphasize my agreement as well with the comment you just made about the costs of behavior and their ramifications in health costs. We have got to address both.

I was at D.C. General about a year ago and an emergency room doctor there said that the average costs of treating one victim of violence—the average cost in D.C. General—was $16,000. Some were much higher than that; others were lower. But that is what they feel the average was.

I combined that bit of information with a report that was recently in the Wall Street Journal that said that in 1960 we had 81 murders in Washington. Last year we had well over 450. I do not recall now the exact number.

But if you take that $16,000 and see the proliferation of murders alone, not to mention all the other acts of violence, you get some appreciation of the magnitude of the problem, just from a social behavioral point of view; and how little any health care reform bill in and of itself can do to address that concern.

I guess my first question would be, the degree to which you would associate substance abuse with violence. I know there are a lot of other factors. But where in the myriad of factors would you put substance abuse as the root cause or as a root cause?

Dr. SULLIVAN. It very definitely contributes significantly, Senator Daschle. As you cited the figures of $144 billion cost of substance abuse, that is real. But in addition to that is again the tremendous social disintegration that is associated with that.

As you know, one of the reasons that the spread of the AIDS virus is so rampant among those using IV drugs is, of course, the breakdown of social institutions around these individuals as op-

posed to the AIDS virus and other segments of our society. It is a difficult group to reach.

The associated crime, burglary and robbery that the drug user often resorts to support his or her habit, prostitution and other associated factors. All of these contribute very significantly. So I view the problem with drug abuse as certainly among the top five or six public health problems that we have. And it is related to some of the other problems that we are addressing as well.

Senator DASCHLE. Does it matter and can one even determine the relationship between substance abuse and social disintegration, especially family breakdown? Is one the cause of the other? They are so interrelated. But would it matter if we could determine with greater clarity which came first?

Dr. SULLIVAN. Well, it is always difficult to be that specific. But we do know from various studies that, again, children who grow up in single parent families are twice as likely to become involved with drug use. So, clearly, we have a situation where one of the social consequences or psychological consequences of growing up in a single parent home is indeed the greater likelihood of turning to drugs.

Let me add that as in so many instances when they are talking about social behavior, I clearly do not mean to in any way condemn single mothers. I have pointed out many times that many single mothers, where it really has been the father who had abdicated his responsibility. Many single mothers are working very hard to provide a home and security for their children.

So this is a problem that has to be looked at as both a problem involving both of those parents. We need to find ways to indeed see that the fathers of these children meet their responsibility because of the important impact this will have on the future of those children.

Senator DASCHLE. Let me ask you if from the inside you can give it to us with the candor that comes with having been out of office for awhile. It is estimated that there are 280,000 drug dependent and alcoholic women who are mothers, pregnant women.

I am told that publicly funded treatment only allows us to serve 11 percent of them. Recognizing the magnitude of the social consequences and not more effectively dealing with the greater percentage of them than that, what happens internally? Is it strictly budgetary pressure that prevents us from more effectively reaching out to a number much larger than 11 percent? Are there other factors that go into that budgetary decision making that preclude that?

Dr. SULLIVAN. Well, Senator Daschle, I think clearly the budget pressure is there. That is a very significant factor. But it is also, I think, because we have not yet as a nation taken the drug problem as as serious cancer that it represents.

Senator DASCHLE. Really?

Dr. SULLIVAN. And we have to have a greater will. Because among other problems that get in the way of having adequate drug treatment is really the difficulty in placing treatment sites. That is, many people will agree that we need to have more drug treatment sites, but they want it on the other side of town. They do not want to have it down the block or two blocks away.

We know that people who are addicts are not really very socially very mobile. That is, if it is a mile away, it might as well be ten miles away. It needs to be where the people are. So one of the problems that we still confront is resistance of having drug treatment sites in many localities. So it is both money, but I think we need to have a stronger greater commitment by our Nation in addressing the problem of drug abuse.

Senator DASCHLE. Thank you, Dr. Sullivan.

The CHAIRMAN. Thank you, Senator Daschle.

Senator Durenberger?

Senator DURENBERGER. Mr. Chairman, and Mr. Secretary, I was reading the latter part of your statement in which you outlined some of the accomplishments in your administration and I applaud them all—the blueprint of national objectives; the reorganized HHS, particularly the children and families; the initiatives in food labeling; the bully pulpit; violence as a public health problem; the minority health at HHS.

I would like to ask you the same question that I have asked your successor on a couple of occasions. That is the question about the responsibility of government at various levels and the loss of the sense of community in America.

I was so pleased to see that article in the New York Times Saturday because like a lot of my colleagues I have been making the same speech for a number of years—that the biggest problem in America today is not the 36 million uninsured, it is the declining health of our communities.

And even if we insured everybody with a comprehensive plan, that had chiropractic and mental health and everything in it, we would not solve the nation's health problem. So I am pleased to see some recognition of this dimension of the problem. And yet I do not hear—and I have been here now 15 years, other than Ronald Reagan in the early 1980's and occasionally in this committee—I do not hear anybody talking about the more appropriate role of community and the more appropriate responsibility of local government, local communities to deal with some part of this problem.

I look over there at the City of Minneapolis and there is 45.7 percent of births to unmarried women—higher than New York City, only 45.2.

About 2 years ago when I was at a hearing in Minneapolis, I asked the head of public health for Hennepin County, what is the biggest health problem in this city and this community and he said violence. We began to talk about it. He made the observation, which I have come to believe is true, that is, this community, Minneapolis is resource rich. But we cannot match up the community's commitment with the people that need it.

I have lived in this community long enough to know that some of our colleagues are trying to do something about it. One of our colleagues on the House side has gone into his community with volunteers and he has found as many of the people as they could find in need.

Then they took all of the Federal programs and all of the City programs to meet those needs and the people that are supposed to implement them, and they matched them up. The people who were

supposed to serve the community were not in the same places as the people in need.

I hate to have to use that example, but it is a real example of what is happening, has been happening now for a number of years, by federalizing the response to all of these basic community needs. And yet, would you speak to the appropriate role of the national government in dealing with some of this.

I can understand the poverty part. I mean I understand that as being a national situation. This committee has a lot to do with the current state of affairs and I would hope would have something to do with some changes in it. But I cannot understand what any of us here or upstairs in the Labor and Human Resources Committee are going to do about these specific health problems, the behavior problems and all that sort of thing.

We have tried for 30 years to generate answers and the problem keeps getting worse.

The CHAIRMAN. It keeps getting worse.

Dr. SULLIVAN. Thank you, Senator Durenberger. Let me say this. I agree with the premise of your question. That is this: In my comments you will note that I stated that we needed to have the private sector involved in our local value generating institutions. This is not a problem that you are going to solve with Federal laws or Federal approaches.

You are talking about how people live, how they organize their lives. That is dependent upon their neighbors, their churches, the organizations that they are a part of. They are the ones they turn to to develop their moral compass.

We are a pluralistic society. So, therefore, the Federal Government cannot come up with a program that is going to fit all segments of our society. We value our diversity and clearly we need to use that diversity in diverse approaches to address them. I think that all of these—using the private sector, using our local organizations—really would have as one common denominator strategies to strengthen our family. If we could do just that.

The CHAIRMAN. Strategies to strengthen our families.

Dr. SULLIVAN. Strengthen families. Keep families together so that children grow up where they have the benefit of both parents. That is not only financially. That is very important. But also as role models and as advisors.

Clearly, that would do a lot towards addressing problems of violence, of drug abuse, of teen pregnancy and others. Now that certainly by itself will not do everything. But I think that that is where the most important focus needs to be.

The CHAIRMAN. Thank you, Senator Durenberger.

Senator Chafee?

OPENING STATEMENT OF HON. JOHN H. CHAFEE A U.S. SENATOR FROM RHODE ISLAND

Senator CHAFEE. Thank you, Mr. Chairman.

I want to join in welcoming Dr. Sullivan back. I have great admiration for him as he knows, and I was very pleased to work with him when he was Secretary of HHS. I think your testimony here today was extraordinary. It had some good news in it. On page 2, where you talk about the decline in death rates due to heart at-

tacks from 1978 to 1988, that all came from education. The awareness that people have changed their eating habits to a tremendous degree—and where you talk about power-walking and what this can do for your health is good news.

I thought your statistics on the bottom of page 3 where you talk about eliminating poor health by improving our health behavior, the statistics you had—eliminating 45 percent of deaths from cardiovascular disease; 25 to 30 percent from cancer. While, in 50 percent of the disabling complications of diabetes, I did not know that last statistic, which is a surprise.

You talked about the couch potato generation and the young people. I will say this, always looking for the good news, I certainly have been extremely impressed and pleased by the increase in girls athletics in the schools, high schools. Page after page in our local newspapers filled with field hockey results, girls soccer and so forth.

So I believe, that would translate into more sports participation by girls, just like the boys are getting their sports from football and basketball and so forth.

Now what you say—and Dr. Schwartz in his testimony will also talk about spinal chord injuries and their costs are true. Many of those, the life time costs of care is up to $600,000 per case—page 9 of his testimony. I believe that.

That is why I think we ought to ban all handguns. You and I have discussed that. The Chairman and I have discussed that. One approach is to ban the ammunition. That is a good approach. I would just ban them all, except for policy and military and certain licensed security personnel and so forth.

I have not received overwhelming support on that, I will confess. But nonetheless, we are going to stick at it because it is hard to put a price tag on it. Do you think it is accurate to multiply by three the number of deaths to arrive at the number of injuries? In other words, if the City of Washington has 600 deaths by handguns a year, can you figure that 1,800 roughly?

The CHAIRMAN. Yes.

Senator CHAFEE. At least. So the deaths, they are killed. That probably, the cost is quite limited except for the terrible tragic after affects, but not dollar affects frequently. But the hospitalization, the medical costs, that arrive from those who are so shattered from these bullets, we have come up with a figure of $4 billion attributable annually. I suspect direct medical costs for handguns is probably much more than that.

But the thing that astonished me was this chart you have here. I would like to call people's attention to Detroit—71 percent of the births are to unmarried women. That is an incredible percentage. I do not know what we can do about it.

I do believe that there now is in our movies and everywhere else kind of a glorification of sex, that one sounds prudish if they deplore it. But when the Chairman and I were growing up there was the Hays Commission that regulated all the movies. And we were kept from seeing anything naughty.

As a matter of fact, any scene in the bedroom involving a man and a woman, three feet had to be kept on the floor. That is really restrictive of any sex activities, I think. [Laughter.]

But the power of movies on individuals is incredible. In the New York Times today there is an article about young men emulating some movie in which apparently the way to play chicken is you lie down in the middle of a road at dark, in the night, and then see if a car will run over you.

Now that is the ultimate in chicken. In nice Bayville, Long Island they were doing it. And the consequences are terrible injuries from this.

The CHAIRMAN. Bayville?

Senator CHAFEE. The idea is to see how long you lie there before you get out of the way. I do not know what movie this stems from. I see somebody nodding his head.

Mr. O'BRIEN. The Program.

Senator CHAFEE. That is the movie?

Mr. O'BRIEN. Yes.

Senator CHAFEE. Well, if anybody is influenced by something as dumb as that—[Laughter.]

Obviously something that has the allure of sex is much easier to sell in a movie. [Laughter.]

Now what the solution is, I do not know. But I am appalled by those statistics up there. I mean, maybe Detroit comes out at 71 percent, but the others are way up there. Nice Minneapolis, all those well behaved Swedes—47 percent of the births are to unmarried women. The consequences of this are devastating to our Nation in everything that you have pointed out. I just do not know how to handle that. I will turn that section over to the Chairman.

I will stick and deal with violence and implore everybody to come on my bill to ban all handguns. Now they say, all the good guys will turn them in; the bad people will keep them. We will get them eventually if there is no more sales, no more manufacturing, the whole transfer, importation is banned. We will get every handgun eventually. The increase of these handguns is incredible.

The CHAIRMAN. Yes.

Senator CHAFEE. Nice towns in Rhode Island, they are finding them in the school lockers—handguns.

The CHAIRMAN. May I say, Senator, if you had heard earlier from Senator Pryor about Little Rock.

Senator CHAFEE. I heard the Senator talk about that. I appreciate the support you have given on the handguns. I might say that this is devastating to a whole generation of youth, and especially black youth, in our country. It is taking out a generation.

Dr. SULLIVAN. Let me say, Senator Chafee, that first of all I was very pleased to be there at the press conference when you introduced your bill and to, indeed, lend my support.

Senator CHAFEE. Thank you for making the effort to be there.

Dr. SULLIVAN. Thank you. I certainly support that effort wholeheartedly. I am pleased also that a companion bill was introduced on the House side by Congressman Major Owens, a member of the Black Caucus. I believe that more than half of the members of the Black Caucus are supporting that.

That does represent a serious problem in our society. Of course, I am sure that all of you saw the study that showed that if there is a handgun in the home that you are much more likely to be injured or killed having that handgun there. Rather than providing

overall protection, that this really provided a weapon which could be turned against the owner.

So clearly I support that effort. We are losing too many of our young people because of homicides in which handguns are the principal tool used. That means not only that tragedy, that means that there are those fewer young men to form families or if they have families to support them.

You mentioned that perhaps with an instant death there is no cost. There is a cost. The cost is lost future earnings if that individual has a family and has children. So that does represent severe costs. So I support those efforts. I think increasingly our public is understanding that we have a major problem.

As you know, we are something like 8 or 10 times more violent in terms of number of homicides than the number two nation in the world. We are out by ourselves. So clearly we must address that.

Senator CHAFEE. Could I just say one other thing, Mr. Chairman?

The CHAIRMAN. Of course you may.

Senator CHAFEE. That this is tough going to sell a ban because the answers peddled by some people and indeed by the handgun manufacturers shows some mother kissing her children good night and she knows they are going to be secure because she has a Colt 45, woman's version, somewhere in the house. [Laughter.]

The Lady Colt it is called, I think. Now everything that the Chairman and you have said is absolutely true. The chances of someone being killed in that family are far greater with a handgun around than if there was not.

Second, about the innocent victims, you might say, oh, these are a bunch of thugs killing each other off down in Southeast Washington. Not at all. They are innocents caught in the cross fire like that little girl 4 years old. What more innocent? Going to a local football game is killed.

So I just invite everybody to come on and do not let the NRA scare you off.

The CHAIRMAN. Can I just say that, perhaps for the record, John Chafee is a former combat Marine officer and he does not have to explain why he does not like a particular kind of gun, or a particular caliber.

Now on another subject, I was in Bayville 2 weeks ago and nobody told me about this.

Senator CHAFEE. Well, this happened last night, over the weekend.

The CHAIRMAN. It is a nice town on the north shore. It got battered a bit by that Nor'easter in December. I am going to have to go back up. They have a problem if that is what they are up to. I am going to find out about that movie and we thank you for that local news.

Senator Rockefeller?

OPENING STATEMENT OF HON. JOHN D. ROCKEFELLER IV, A U.S. SENATOR FROM WEST VIRGINIA

Senator ROCKEFELLER. Mr. Chairman, I will not ask questions. I was very moved by what Senator Chafee had to say and I want

to welcome Dr. Sullivan back here. I remember there were some times when there were some exchanges, probably between the two of us, and from this side of the aisle, with you that were not all that pleasant during the last 4 years.

But one thing never altered in my own thinking. That was something that I have heard people say many, many times since then, that you have an absolutely passionate commitment to preventive care, to the special problems of urban and rural areas; and you are, as you were then, one of the major leaders in the country on this whole subject.

I respect you greatly, respect what you have been doing greatly, and I just want to say that.

Dr. SULLIVAN. Thank you very much, Senator Rockefeller. I appreciate that. It is a pleasure being back with all of you.

The CHAIRMAN. That is very nice of both of you to say.

Senator Pryor, did you have something?

Senator PRYOR. Yes, just a comment or two, Mr. Chairman.

I, too, want to thank Dr. Sullivan for coming. I would like to add a word of praise for our colleague, Senator Chafee. This is no easy thing. It took a lot of courage for him to introduce such a far-reaching piece of legislation. In addition to being a former combat Marine, as all of us know, he was a very distinguished Secretary of the Navy. So he comes into this battle with fine credentials.

Twenty percent of our population today in America is sitting in a classroom at this moment—20 percent of our population. One hundred thirty thousand of those people sitting in classrooms today took a gun to school with them—130,000 people in America's classrooms. We are jeopardizing a fifth of the American population when they go to school by not providing for their safety or for their security.

Senator Durenberger came across with a very interesting part of this whole equation. That is, the behavioral patterns. What does the government have to do with changing those behavioral patterns?

Mr. Chairman, you have written extensively on this. I was just sitting here making a list and I know that you have been certainly one of those who have been long opposed to smoking. Had the government not gotten involved in this campaign, we would not have seen the rapid decline of smoking. I am convinced of that.

The government got involved in the use of seat belts, and today 60 or 70 percent of the population use seat belts. We have airbags today. Not because Detroit wanted airbags. They fought airbags. They fought emissions standards, but today we have better emission standards. That was because of the government being involved.

In the late 1980's we had meat inspection. Had not the government not done that, that would never have been done. That was the government. Nutritional labeling, that was the government. So we see the government causing some behavioral patterns and changes in those patterns. I think it is in this area that we have to search for the right answer to see if we can change behavioral patterns through changes in the welfare system, health laws, and other regulations.

But I hope it is not too late to start. I think this discussion, Mr. Chairman, is helpful.

The CHAIRMAN. If I could just make the epidemiological point which I think Dr. Sullivan would agree with, when we were dealing with the issue of automobile safety, which began in Albany in the State Government in the 1950's, we made the strategic decision that it was much easier to change the behavior of three automobile companies than 90 million drivers. That principle is around in any medical school.

Senator Bradley?

OPENING STATEMENT OF HON. BILL BRADLEY, A U.S. SENATOR FROM NEW JERSEY

Senator BRADLEY. Thank you very much, Mr. Chairman.

Dr. Sullivan, I know that you have long spoken out against tobacco use and about health costs that are implied, and the advertising that is targeted. When you were in an administration you always stopped short of taking the position in terms of denying the deduction for advertising of tobacco, for example, and now we have a very sizeable tax going to be placed on tobacco.

I know your views and I applaud those views in terms of supporting efforts to reduce tobacco use. In terms of violence, which is another behavior, there are a series of proposals out there ranging from Senator Chafee's ban to a bill that would ban the sale of guns to people under the age of eighteen, to Senator Moynihan's far-reaching piece of legislation. [Laughter.]

It might be called even visionary. [Laughter.]

To ban the sale of ammunition, as well as heavy taxation of ammunition, handguns and assault rifles, the Brady Bill, which is the waiting period, and the ban on assault rifles. So you see that there is a lot of action out there, all focused on guns.

If we talk about violence and behavior though there are other factors, not the least of which is the culture of violence that our children grow up in through the mass media. The idea that we should also be making it unstylish just as now smoking is viewed as somewhat, you know, not really stylish.

Don't you think that we ought to make responsible boards of directors of corporations that make a sizeable amount of money out of programs of violence being directed at young people across the country, whether it be on television or movies or through the recording industry?

Don't you think we ought to do what we can as a government? Obviously, we have certain limitations on censorship and we do not want to get into censorship. But there are maybe some things that we could do to make it unfashionable for the members of boards of directors of some of these corporations to go into a room and just as everybody would look at them because they are smoking, that they would clearly be identified as being the person who is actually kind of in charge of making money out of this violence. What are your thoughts on that?

Dr. SULLIVAN. Well, thank you, Senator Bradley. Let me say first of all that approximately 2 years ago I attended a meeting in Santa Barbara, CA with representatives of the television and movie industry and I spoke to that group. The subject there was the respon-

sibility of those in the media in reducing the display of violence to our public.

Indeed, I pointed out that they do have a corporate responsibility. I am very concerned about the too frequent and too graphic display of violence on our television screens and our movie houses because in spite of protestations by those in the industry there are data that show a number of people are influenced by that.

In the same way that we now have a great recognition of the urgency of getting rid of handguns in our society, I think there is increasing recognition of the fact that this is not simply innocent violence that is harmless, that it does influence behavior.

It also helps to change the social melior in which we exist. So, yes, I believe that those individuals in our society who do take actions which I believe are irresponsible, profiting with actions that really have a deleterious affect on our society, should be singled out and should be censored. Not censored in the terms of good, but censured, I guess.

Because that is an action that I think is inappropriate in the same way that there have been a number of leaders in the black community who have undertaken such actions of white-washing billboards that display advertising in low-income communities for cigarettes and alcohol because these communities are disproportionately impacted negatively by those products.

We need to have a stronger sense of community and responsibility to each other and not have the attitude if it is legal, then it is anything that we do that makes a profit is perfectly permissible. I think we have to have greater responsibility.

Senator BRADLEY. Maybe a Sullivan code on violence.

Dr. SULLIVAN. Thank you.

Senator BRADLEY. That we might get various companies to subscribe——

The CHAIRMAN. A Sullivan Act, yes.

Well, sir, on that thought, we have to thank you for an extraordinarily helpful morning. We have learned so much from you, Doctor. We always did. But we are so much concentrated on this subject right now.

Your proposition that behavioral activities account for a third to a half of medical costs, we are going to hold onto that number. Again, thank you very much for coming up from Morehouse. We will work on that Sullivan Act, too.

Dr. SULLIVAN. Thank you very much, Mr. Chairman. It is a pleasure to be here with all of you and the members of the committee. We look forward to working with you in whatever way we can be of assistance.

The CHAIRMAN. Let us know how you think we are doing, sir.

Dr. SULLIVAN. Thank you.

[The prepared statement of Dr. Sullivan appears in the appendix.]

The CHAIRMAN. We will stand in recess for just a moment so we can say goodbye to Dr. Sullivan.

[Whereupon, at 11:35 a.m., the hearing recessed, to resume at 11:37 a.m., the same date.]

The CHAIRMAN. We will now move to a panel of eminent academicians. One of the most distinguished demographers in our Na-

tion, a very dear friend who is professor of sociology and head of the Luxembourg Income Studies, Dr. Ted Miller, and Dr. Leroy Schwartz, who have given us very carefully prepared papers on our subject.

As is our practice, we will begin in the sort of random way these names get listed. We will turn first to Reynolds Farley. Dr. Farley is the, as I say—I do not want to get him in trouble—but certainly, one of the mnost respected demographers in the nation today with his particular concern with the kind of activities that we are talking about this morning. So you go right ahead, sir.

STATEMENT OF REYNOLDS FARLEY, PH.D., PROFESSOR OF SOCIOLOGY AND RESEARCH SCIENTIST, POPULATION STUDIES CENTER, UNIVERSITY OF MICHIGAN, AND VISITING SCHOLAR, RUSSELL SAGE FOUNDATION, NEW YORK, NY

Dr. FARLEY. Thank you very much, Senator Moynihan. It is a pleasure to be here. I appreciate the opportunity to discuss these extremely important issues.

In 1991, as your earlier chart indicated, a record high, 30 percent of the nation's births occurred to unmarried women, a very substantial shift from the 5 percent figure of 50 years ago.

Your figure pertained to the important trends of the last 2 decades. If we take a longer run view, we find there has not been a consistent shift toward a higher proportion of children born to unmarried women.

For about 20 years after 1940 there was very little increase in the proportion of children born to women without husbands. In the prepared statement figure 1 shows that trends in the proportion of children occurring to unmarried women. You see a very large racial difference there, but the take off or increase begins around 1960.

As you indicated, in 1969 for the first time 1 in 10 children born in the United States occurred to an unmarried woman. By 1983 it was 1 in 4. And unless there is a very surprising reversal of the current trends by the middle of this decade, 1 in 3 children will be born to a woman who is unmarried.

Today 2 out of 3 black children——

The CHAIRMAN. Could I ask, don't we already have that at 29.5 for 1991?

Dr. FARLEY. Yes. We are very close to 1 in 5. There is a very large racial difference, as you have indicated. About two-thirds of black children now are born to unmarried women; and among whites it is about 22 percent, which is the percent among blacks about 3 decades ago.

At first glance you might think that the sharp rise in proportion of births occurring to unmarried women means that women who are not married are having children at a much higher rate. That is not an appropriate conclusion. This rise in the proportion of births to unmarried women comes about because of three trends.

Any one of these three changes increases the percentage of births occurring to unmarried women. The birth rate of married women is an important factor; the birth rate of unmarried women is an important factor; and finally, the percentage of women who are married. The situation producing the first rise in the proportion of children to unmarried women—the rise that occurred after 1960—

came about primarily because a decreasing fraction of women were married.

For 30 years there has been a sharp increase in the average age at marriage, meaning that women are at risk of bearing children before marriage for much longer periods of time.

Similarly, in the 1960's and 1970's there was a substantial decrease in the rate at which married women had children. Figure 2 in the prepared statement shows both the baby boom of the 1950's and early 1960's, and the baby bust which followed, that is, the dearth of births associated with the declining fertility rates of the late 1960's and 1970's.

You might think that it is necessary just to look at the trends in the proportion of births occurring to unmarried women, but the situation was one in which the birth rates of married and unmarried women moved in different directions—namely, there was a much more rapid fall in the birth rates of married women than in the birth rates of unmarried women.

Importantly, you might expect that the birth rate of unmarried women has been going up for a long period of time. We actually find that among blacks from 1960 through the early 1980's there was a consistent fall in the rate in which unmarried black women had children.

What is new about the 1980's, at least since 1985, is the rise in the fertility rate of women who are not married. I have a figure 3 which shows information for three specific age groups of women. Importantly this increasing tendency of unmarried women to have children occurred for all groups since the early 1980's and it has occurred for both blacks and whites.

A very important driving force behind this trend——

The CHAIRMAN. In that sense the ratio reflects a reality and not just arithmetic.

Dr. FARLEY. Yes.

The CHAIRMAN. Earlier on you had an arithmetic effect?

Dr. FARLEY. Yes. Earlier on we did not have an increase in fertility by unmarried women. We actually had a substantial decrease among black women. Since the mid-1980's, we have had an increase in childbearing by unmarried women.

And yet you might ask looking at that, well, how could we get this dramatic change if unmarried women were not increasing the rate at which they were bearing children. And the answer is the delay of marriage. Figure 4 in the prepared statement shows the proportion of men and women at young ages who had married by the last five census dates.

The census of 1960 clearly reflected the pattern of that age. Young women married shortly after they graduated from high school. And almost all men in the early 1960's married by the time they got to age 25.

In 1960 3 out of 4 women, 20 to 24, had married. In 1990 it was only 1 out of 3 women in that young age group who had married. So there has been this shift towards much later ages at marriage. It continues among both blacks and whites; and it portends a time when a significant number of adults will apparently not marry in their life time.

Now, I have done a more technical decomposition here of what are the changes in the proportion of births to unmarried women; and I would stress that the early rise in the 1960's was attributable to the shift away from marriage. In the 1980's the increase is attributable to not only the shift away from early marriage, but to the higher rates of childbearing by women who were not married.

If you wish to think about changes in the proportion of births to unmarried women or if you want to think about policies that might alter this very persistent trend, it is necessary to explain two things which are occurring.

One is this delay in the age at first marriage. It has been going on in the United States and many other countries since the 1960's. Explanations for that typically focus on one of two factors. One view stresses the declining economic fortunes of young men.

Since the 1970's young men who have been getting to their twenties have been earning successively smaller amounts of money, have been experiencing somewhat higher unemployment rates. In other words, young men are in an economically more precarious position now than were young men 10 or 20 years ago.

It may be that these young men are unwilling to take on the responsibilities for a family and they may be viewed by women as unable to provide the economic stability needed to marry and form a family. That is one view.

The opposing view stresses something very different—namely the personal and economic independence of women. By the late 1960's in the United States women were catching up with men in terms of educational attainment. And among recent birth cohorts and graduating cohorts, women are more extensively educated than men.

In the 1970's women started going to the professional schools in large numbers. The census of 1980 reported that women were moving into job categories once reserved for men, particularly the lower level managerial jobs.

Suzanne Bianci's investigation with data from the 1990 census demonstrates that young women made substantial progress in the 1980's in closing gender gaps in occupational achievement and in earnings. Opportunities for young women expanded at the same time the wage rates for young men fell.

One outcome may be that women had fewer incentives to marry; and, indeed, some women may prefer their personal independence, which is sustained to some degree by the occupational and economic gains that women made in the 1980's. If independence is a driving force leading to a later age at marriage for women, so too it may encourage some women to bear a child, even if they do not have a husband.

Thirty years ago having a child out of wedlock was such a deviant act that no national surveys asked people how they felt about it. It was assumed to be universally condemned. But since 1974 national samples have been asked their attitude about unmarried women having children.

They reveal an unambiguous trend toward more liberal views, although the majority of our population still disapproves and when it involves your own family, there is very strong disapproval for out

of wedlock childbearing. Interestingly enough, young college educated women expressed the greatest approval of unmarried childbearing. Given trends in educational attainment and the fact that more liberal cohorts will replace less liberal cohorts, it is reasonable to expect a continued shift toward attitudes approving or tolerating childbearing by women who are not married.

Let me conclude with one brief comment about some of the implications of unmarried childbearing. Many of them have been mentioned here earlier this morning. Undoubtedly some, perhaps many children who are born by unmarried women, thrive.

But in the aggregate, these children are at a substantial risk of poverty, a poverty which is no way mitigated by cash transfers from the welfare systems or by monetary support from their absent fathers.

The census, of course, does not tabulate individuals by what was written on their birth certificate, but it does provide crucial information about these issues. I have a table in the prepared statement which shows information about two contrasting groups of children under age 6.

One consists of those living with their mother in a husband/wife household—that is, the typical household or what used to be the traditional household. The other group consists of children under age 6——

The CHAIRMAN. Yes, traditional.

Dr. FARLEY. Traditional. The other group, are children, under age 6, living with their never married mother who headed her own household. So this would be a never married woman heading her own household with a child under 6. That child necessarily would have been born to an unmarried woman by these demographic definitions.

Considering the New York Metropolitan area in 1990, we find that 10 percent of the children in married couple families were impoverished. Among children under 6 living in households headed by their never married mother, two-thirds were below the poverty line.

We are often interested in the other end of the income distribution and we might define as economically secure those households who had incomes at least five times the poverty line. Twenty-eight percent of New York's children under 6 living in a husband/wife household could be termed secure. In contrast, only 1 percent of the children who were living with another married mother.

There is also information in the census about the average AFDC payments to these women who had not married, but who were taking care of their child in their own household.

In 1990 in the New York area, just under one-half of the never married mothers who headed a household with a child under 6 received AFDC income. Those who received it obtained an average of about $4,700 in income. That is far below the poverty line for a mother/child couple which was $8,500 when the census was taken.

Cash payments from the transfer systems and monies from absent fathers brought no more than one-third of these unmarried women who had children above the poverty line; and thus, poverty is very much associated with childbearing by unmarried women.

Thank you very much.

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[The prepared statement of Dr. Farley appears in the appendix.]

The CHAIRMAN. Thank you and very direct, indeed, sir.

Dr. Miller, you are going to speak to us now. You are an international authority on the medical care costs of injury and violence and the savings achievable through prevention.

STATEMENT OF TED R. MILLER, PH.D., DIRECTOR, SAFETY AND HEALTH POLICY PROGRAM, NATIONAL PUBLIC SERVICES RESEARCH INSTITUTE, LANDOVER, MD

Dr. MILLER. Thank you, Mr. Chairman. My testimony covers four topics—injury's share of medical care spending; the medical costs of violence; the costs of injuries to employers; and the medical savings available through prevention.

You may know that injury is the leading cause of death from ages 1 to 45 and the third leading cause overall. Injury also is the largest cause of medical spending from ages 5 to 50. Among the very young and the very old, it ranks second.

In 1992, medical spending was $522 billion. That excludes nursing home care and insurance claims processing costs. Injury caused $70 billion of the spending. That is 13 percent, second only to heart disease at $80 billion.

Violence is a major killer and a major piece of our injuries. We lack a good count of non-fatal firearm injuries, however.

I ran some estimates for this hearing and they are rough. In 1992, I think that medical spending on firearm death and injury was about $1.9 to $2.7 billion. Wage losses were perhaps $20 to $25 billion more; and quality of life losses were three times that amount.

By comparison, civilian firearm sales were only about $2.1 billion, comparable to the medical care costs of the firearm violence. Ammunition sales were perhaps $1 billion to the public. Taxing arms and ammunition sufficiently to recoup their societal costs could raise considerable revenue, perhaps more than $20 billion a year. Though I would imagine the firearm sales would drop some.

Recent research suggests that if taxation reduced sales, it also would reduce both suicide and homicide. In 1992 the total cost of medical spending due to violence was at least $14 billion. That is 20 percent of our injury costs. It is more than 2 percent of the total medical care costs in this country—almost 3 percent.

Senator BRADLEY. Mr. Chairman, could I ask, are all these numbers in your testimony?

Dr. MILLER. Yes, they are.

Of this amount, suicides and hospitalized suicide attempts were $3 billion. I lack data on nonhospitalized suicide attempts. There are six crimes that I have costed—murder, rape, robbery, assault, drunk driving, and arson. And together they cost almost $11 billion. That is very conservative, because I have no costs for child abuse. Further, my costs of rape and domestic assault are based on reporting, and we know those crimes are very much under reported.

Violence also creates large mental health care costs. In 1991, crime caused between $3.5 and $4.0 billion in mental health care costs. That includes child abuse. In addition, treatment of adults who were abused as children was another $4 to $6 billion. Mark

Cohen of Vanderbilt University and I estimate that for adults alone the unmet mental health care needs due to violence were at least $5 to $6 billion for the victims. That does not even look at the fear violence is creating in our communities right now and the resulting mental health care costs.

I think we need to raise alcohol taxes. I view drunk driving as a violent crime. It is an illegal act. It maims; it kills. This crime causes almost $7 billion in medical care costs annually—1 percent of our total spending.

That figure only includes crashes that are caused by alcohol. Alarmingly, a drunk driver is behind the wheel for one in every 100 miles driven in this country. And every mile driven drunk costs the rest of society $2.55.

Alcohol also is implicated in every other kind of injury as a facilitator or a contributor. It is implicated in a number of other health care costs. If we look at the costs of alcohol to people other than the drinker, it is 63 cents a drink. That is, in my opinion, the optimal tax on alcohol. It equates to $1.38 an ounce. It would generate $85 billion a year in revenue. If it reduced drinking, it would also reduce health care costs.

I turn now to the cost of injuries to employers. Injury is a knife in industry's side. It causes 19 percent of employer's health care bills—$35 billion out of $184 billion. It causes 48 percent of employer's sick leave and disability payments.

Overall, injuries cost employers about $1,000 per employee per year. These are preventable almost entirely. Preventing them saves money and saves lives. Every $1 spent on child seats for children saves $2 in medical spending. Every $1 spent on bicycle helmets for children ages four to fifteen saves $2 in medical spending. Every $1 spent on programs to enforce State laws against serving intoxicated patrons saves $10 in medical spending. Every $1 spent painting center lines and edge lines on our roads saves $3 in medical spending. The list goes on.

In violence we have many promising approaches but we have few proven ones. The proven approaches are home visits to prevent child abuse, as has been implemented statewide now in Minnesota, gun control and getting guns out of homes.

In conclusion, violence and unintentional injury cost $70 billion last year in medical spending. Those costs are often unnecessary. Injuries can be prevented cost effectively. Injury control can and should play a leading role in health care cost containment. That requires more funds for prevention and for research to develop proven interventions. Alcohol and firearms are major health care cost factors. Fully taxing to recover their societal costs could raise more than $100 billion annually.

Taxation can reduce health care costs by deterring drinking and violence while helping to finance health care.

Thank you.

[The prepared statement of Dr. Miller appears in the appendix.]

The CHAIRMAN. Thank you, Dr. Miller. I cannot help but interceding here but to say there is a passage in the old testament which requires that persons who build houses shall build parapets on the roof, lest people fall off onto the ground and injury them-

selves. It is a very early example of epidemiological thinking. [Laughter.]

And now to a paper by a very dear personal friend, and a very most distinguished American, international sociologist, Dr. Lee Rainwater, who is going to speak to us on the subject of births to unmarried women, and policies for prevention and protection.

STATEMENT OF LEE RAINWATER, PH.D., PROFESSOR OF SOCIOLOGY, HARVARD UNIVERSITY, AND VISITING SCHOLAR, RUSSELL SAGE FOUNDATION, NEW YORK, NY

Dr. RAINWATER. Thank you, Mr. Chairman. My colleague, Reynolds Farley, has summarized the demographic and social factors that lie behind the trend we see in the graph here. I would like to suggest some ways one might think about the social context in which all of this occurs and discuss common policy options for dealing with the potentially precarious socioeconomic situation in which these families find themselves or can find themselves in all countries, not just our own.

In some ways, as is the case with many social problems, the rising ratio of births to unmarried women is the result of a signal success in private and public policy. The diffusion of effective family planning methods, which received a major impetus in the 1960's, has enabled many women to choose when to have children.

The CHAIRMAN. Dr. Rainwater, if you could bring that microphone a little closer so people in the back can hear you better.

Dr. RAINWATER. It has enabled many women to choose when to have children and it, as a result, has encouraged later ages at marriage and for many married couples has lifted the burden of unplanned pregnancies and excess fertility.

In thinking about my testimony today, I was reminded that in the 1950's my first public policy research was concerned with understanding the family planning difficulties of poor and modest income married couples. Then the problem of controlling fertility was a big one for married couples.

Family planning clinics needed to understand marital relations better in order to do their job better. Since then the development of more effective contraceptives and changing sensitivity on the part of physicians to issues of family planning and the growth of public funding for family planning clinics has had a dramatic impact on the ability of women and men to avoid marriages forced by pregnancies and to tailor their family size as they determine is best for them.

Thus, our success at family planning for married couples, since it has not been matched by similar success in family planning for unmarried men and women has resulted in the rising ratio of births to unmarried women that drives particularly the early part of this period.

Given this policy failure, we are confronted with two kinds of challenges for future social policy. We are confronted with the necessity for policies for prevention and the necessity for policies for protection.

The family planning policies for unmarried women have not been successful and this may be a textbook illustration of a standard sociological paradigm for understanding social problems.

Social problems arise as a result of conflicts in society. That is, we want contradictory things. On the one hand, we want unmarried women not to have children whom they can ill afford to care for. On the other hand, we want to uphold traditional notions of sexual morality, so we are reluctant to promote family planning services to unmarried girls and women, particularly the former.

It is not just that liberals think one way and conservatives another, but many people, including those who establish and implement policy, are immobilized by these value conflicts.

The CHAIRMAN. As, for example, the U.S. Congress. [Laughter.]

Dr. RAINWATER. It is interesting that in many ways we have been blind sided by a revolution that was announced, but did not happen for a long time and then did happen. Over the decades, up to the 1960's, social observers often announced that a revolution in sexual mores was in progress. But when social scientists looked, they found little evidence that this was so.

However, in the 1960's, the revolution did, indeed, take place. Since then the operating, as opposed to the official morality of the country, has been one that expects sexual activity among unmarried teenagers and adults.

Because we find it so difficult to cope with our value conflicts about issues arising from this revolution, it is a constant temptation to look for ways to undo the change through public policy. But these cultural and social shifts are not controlled by policy. Policy can only adapt to them or ignore them and tolerate the consequences of so doing.

As more surveys of sexual behavior are done in other countries, we are learning that the level of nonmarital sexual activity is about the same in most European countries as it is in this country. But in those countries the value conflict is not so intense. As a result, it appears that although unmarried teenagers and adults are as sexually active as are those in this country, unplanned births are rare.

There are probably many reasons for this. But one certainly has to do with the availability of and the promotion of family planning in connection with the regular operation of health services and in some countries with the operation within schools of those health services.

The CHAIRMAN. Could I interject just to say, the very term "family planning"—I know it is something very different from what you are talking about here—that contradiction is right in the terminology, is it not?

Dr. RAINWATER. Exactly. It is a euphemism for contraception.

Senator CHAFEE. Could I just ask a quick question? Dr. Rainwater, would that be true, say, in Italy? In Italy is there an abundance of contraceptives available for young people?

Dr. RAINWATER. I do not know much about Italy. But my impression is that the rate of births to unmarried women is quite low in Italy.

Senator CHAFEE. I would expect so.

Dr. RAINWATER. But most of the surveys we have are from northern Europe, the ones I have seen so far.

The CHAIRMAN. I think Senator Chafee was asking about family planning services. I think they would be as common in Italy as they are in Norway.

Dr. RAINWATER. That would be my guess.

One of the positive effects of the proposed national health program should be the facilitation of family planning services for all women and men, but most particularly for the unmarried and the young.

Clearly a serious effort at providing family planning services for unmarried men and women could reduce the ratio of births to unmarried women. The ratios among the poor, particularly those in areas of concentrated poverty, might still be high compared to those for other social groups because poverty itself persuades people that they have little hope for bettering themselves and that undercuts motivation to control one's situation.

By the same token, however, programs that impress on poor people that the rest of society is doing things to help them pull themselves up can have a positive effect on the efforts of the poor, the efforts the poor make for themselves and their families.

Now the question is what about policies for protection. The statistics we have reviewed showed that 30 percent of our new fellow Americans are born to unmarried mothers. Extrapolating to the turn of the century and taking into account the different rates for whites and blacks, the rate over the last decade for whites has been going up at about 7 percent a year, that for blacks at about 2 percent a year. Extrapolating to the turn of the century, that is a guess of ratios of 40 percent for whites and 80 percent for blacks, unless something happens and the rates begin to decline.

The CHAIRMAN. There is a number. By the time we get our health care system in place, we will have an illegitimacy ratio or nonmarital ratio, whatever the euphemism is, of 40 percent.

Dr. RAINWATER. Over 40.

The CHAIRMAN. And heading for 50.

Senator RIEGLE. Would it not be higher than 40?

Dr. RAINWATER. It will be a little over 40.

Senator BRADLEY. During its 7 percent and 2 percent?

The CHAIRMAN. Yes, it would be a little over.

Senator GRASSLEY. And will it not continue to go up even after we get their reform in place?

The CHAIRMAN. Well, those lines keep going and we have not seen it, and they do not change.

Senator GRASSLEY. Yes.

The CHAIRMAN. If I could make the point, the correlation that is in my statement for that line and the black rate is as high as for the white rate, which means that even at high ranges that straight line keeps coming.

Senator GRASSLEY. So then your natural question is, what are we going to do about that problem.

The CHAIRMAN. Why don't we let Dr. Rainwater tell us.

Senator GRASSLEY. Health care reform is not going to take care of that problem.

The CHAIRMAN. I detect a point of view in Senator Grassley's comment. [Laughter.]

Dr. Rainwater.

Dr. RAINWATER. Now, what about the situation of children in single-parent families, solo mother families, whether formed by births to unmarried mothers or by divorce or by separation? We know that few of those children will, in fact, have more than intermittent social and financial support from their fathers. They and their mothers are very likely to be poor, particularly in the early childhood. In this respect children of unmarried mothers share their fate with children in separated and divorced families.

Yet, these people will be workers in a generation's time. American society will have to rely on them to produce, to finance government, to pay the retirement income of their elders. The social cost to the children, their families and the rest of us is likely to be great if policies for protection are not put in place.

One way of exploring issues of policy is to compare the experience of the United States with that of other rich countries. The United States has a higher proportion of single parent families than other advanced countries. I draw here on data from the Luxembourg Income Study, which assembles social and economic survey data from some 20 nations.

We find that in the mid-1980's the United States had the highest rate of persons in families headed by a solo mother—19 percent. Several other countries, however, had significant numbers of persons in such families. For example, Sweden and the United Kingdom in the 14 to 15 percent range; Australia and Canada at 11 percent.

But there were great differences in the poverty rates of people in solo mother families. Three countries had very high rates—the United States at 58 percent; Australia topped us with 61 percent; and Canada with 51 percent.

In sharp contrast were countries such as France, the Netherlands, Sweden, the United Kingdom, which all had rates under 20 percent. The question then is, how does this come about, why these enormous differences. They are much greater for solo parent families than they are for married couple families, although there too our poverty rates are high compared to other countries.

In two of these countries, France and Sweden, a higher proportion of solo mothers have earnings than in the United States. But in two others, the United Kingdom and the Netherlands, the proportion is much lower.

Variation in how many solo mothers work and how much they earn play an important role in reducing poverty, but it plays a bigger role in some countries than in others. And it is the same with transfers.

Other countries have many different kinds of transfers for solo parent families. Most of those transfers go to families who also have earnings. But transfers include child allowances, enforced child maintenance payments, housing allowances, as well as traditional Social Security programs, like unemployment insurance, survivors and disability potential. Together, both loom large in the income package in these countries.

Transfers to solo mother families who have earnings average from 50 percent to two-thirds of the poverty line in countries like the Netherlands, Sweden, the United Kingdom; and they average 40 percent in France and Australia. So it is the combination of the

two that is driving this big difference in rates between on the one hand the former British colonies and on the other hand the continental European countries.

Even among solo mothers who do have earnings, we find the U.S. has a very high rate—42 percent of our solo mothers who have earnings during the course of the year are poor. They are poor because although they have earnings their earnings are low and the transfers to the working poor in this country are particularly low.

Working solo mothers in Canada are somewhat better off. A third of them are poor. But there too earnings and transfers are low. In Australia working solo mothers do not earn very much. They have low average earnings, but their transfers are higher and as a result only a quarter of them are poor.

Then one drops down to countries like France where both earnings and transfers are high; and Sweden where there is an extremely low poverty rate for working solo mothers—and 95 percent of them work—and the poverty rate is low because they have both high average earnings and high transfers.

So, from a comparative study of solo mother families we see that that transfer policies have to work hand-in-hand with policies that facilitate solo mothers' desires to work and earn a living wage.

Child care policies can do this in two ways. They give mothers time for work and they employ some of them. In a country like Sweden that is a very important part of the very low poverty rate—the fact that so many of these mothers work in child care.

Transfer programs such as the earned income tax credit, which do not penalize work, can have a large impact on solo mother poverty. And finally, universal medical insurance, which allows mothers not to worry about losing Medicaid if they work, can also facilitate working out of poverty.

Thank you.

The CHAIRMAN. Take that, Senator Grassley. [Laughter.]

[The prepared statement of Dr. Rainwater appears in the appendix.]

The CHAIRMAN. Now to conclude our panel, which is fascinating, Dr. Schwartz is going to speak to us on the American health care dilemma. And to use a phrase that I believe, Senator Grassley, you have used. Senator Grassley, you were earlier speaking on the subject of pathology and Dr. Schwartz is speaking of a large pool of pathology flowing into the health care system and the higher health costs of the United States.

Good morning to you, sir. Proceed. Thank you for coming.

STATEMENT OF LEROY L. SCHWARTZ, M.D., PRESIDENT, HEALTH POLICY INTERNATIONAL, PRINCETON, NJ, ACCOMPANIED BY MARK W. STANTON, VICE PRESIDENT FOR POLICY RESEARCH

Dr. SCHWARTZ. Thank you, Mr. Chairman. If you ask some Americans nowadays what is wrong with the health care system, they will tell you it is broken. It costs an awful lot of money, poor access, et cetera. But I found if you ask them, what about our education system, they say it is broken. It costs a lot of money. Children are afraid to go to school because of the fear of violence in the schools. And if you ask them about our welfare system, they say it is bro-

ken. You cannot do anything about it. It is costing an awful lot of money and it is not working.

And if you ask them about our criminal justice system, they will say it is broken. It is not working. The jails are full. And if you ask them about our immigration system, they will say the same thing—it is broken and it does not work well.

The CHAIRMAN. Thank God for Congress. [Laughter.]

Dr. SCHWARTZ. Well, for me and for all of us, I think the big question is, are the systems broken or have the demographics of the country, changed so much that the amount of pathology poured into all these systems has overwhelmed all of the systems? I will limit myself to the health care system.

I think probably that is what has happened. I think we have to turn our attention to what is happening demographically in this country—chart 1.

That is a small chart. In Princeton, we make very small charts.

Senator BRADLEY. The budget crisis.

Dr. SCHWARTZ. That is right.

What I show by this chart is: We are concentrating our efforts on the health care system—providers, payers, access, quality—when, in fact, I think the problem lies upstream of the health care system itself with a pool of pathology, produced in this country and not produced in other countries, at least not to the same extent.

There is not the same problem in Sweden, Switzerland, Germany and perhaps even Canada. So that the solutions are going to depend upon this factor also. We have all these social and demographic factors which add to this.

Now one of the ways that other countries take care of health care and take care of the social problems is, they pour a tremendous amount of money into their Social Security system—chart 2.

If you take a look you will see that Netherlands, France, Sweden——

The CHAIRMAN. Are we on that second page here?

Dr. SCHWARTZ. Yes, we are.

The CHAIRMAN. The expenditures for Social Security and health care?

Dr. SCHWARTZ. That is right. As you see, they spend on average almost a third of GNP on Social Security and the United States spends only 13 percent.

Senator RIEGLE. Could I just stop you? You say Social Security and our retirement programs, are you talking about the whole broad range of Social Security programs?

Dr. SCHWARTZ. Yes.

Senator RIEGLE. I think it is important that we not mislead.

Dr. SCHWARTZ. These are data from the International Labor Organization.

Senator RIEGLE. Right.

Dr. SCHWARTZ. We are going to update them. When you look at our health care, what we spend, you see that the United States spends more as a percentage of our GNP than any of the other countries.

When you add the two together and you look at health care and Social Security, you see that the United States still is very low.

That, in fact, most of these other countries spend a tremendous amount on their Social Security.

One of the things we suspect is that they are spending for their health care within the Social Security budget, and we are spending for our Social Security within our health care budget. That is why the health care may be very high in this country.

Let me see the next one—chart 3.

Dr. SCHWARTZ. This chart is an overview showing that we pay for more than health care with our health care dollars. What we have done here is we have medicalized our social problems in this country. Now it may be that we do that to get them paid for. Perhaps people like to pay for health care and not for social problems.

As you can see, this chart includes smoking, drug abuse, unsafe sex, violence, even gambling. Not long ago an article in the New York Times showed that about 3 percent of Americans were heavy gamblers and it had an interview in which a reporter asked, "How do you get paid for that." And the gentleman answered, "Well, we call it depression and we put it on the health care bill. That is how we get paid."

So, in fact, American providers have learned how to get paid for these social problems by simply medicalizing them, i.e., giving a medical name for the problem. Of course, that presents problems: It takes away an awful lot of the responsibility for some of these things.

Here are some of our cost estimates. That is what everybody seems to want. I am very happy to say that these numbers are very close to what Secretary Sullivan has said when we get down to the bottom. In addition to medicalization we have the biggest poverty population of any developed country. And we have the medically indigent to a large extent as well.

Also, America's cultural attitudes are different from other countries. We try to save all our babies. We spend a lot of money doing it. We spend a tremendous amount of money in the last 6 months of life. Other countries have made a decision that they are not going to save some of the babies and they are not going to save some of the older people. That is a social decision and I do think that is a decision that is made for doctors and patients alone.

Fraud and abuse, according to a GAO estimate, is up to about $90 billion. If you take these costs and add them up, about a third, $300 billion of the $930 billion total estimated to be spent on U.S. health care in 1993 is possibly being spent for factors other than health care, in particular social factors.

If you subtract the $300 billion from the $930 billion U.S. health care costs are in the same range as Canada—10 percent of GNP.

Now I would like to take a couple of examples.

The CHAIRMAN. Dr. Schwartz, your colleague has not been introduced. We just want to welcome him.

Dr. SCHWARTZ. That is Mark Stanton, who does research with us and is our vice president of policy research.

The CHAIRMAN. Good morning, sir. We welcome you.

Dr. SCHWARTZ. What I would like to do is take one example and follow it a bit—chart 4. Since we are very interested in drug offenses you can see that America has by far the highest number of drug offenses per 100,000 people in the industrialized world.

If you take a look at Japan, we are more than 200 times as high as the Japanese, which gives some idea of the difference. And Canada is the second highest. I suspect that Canada's high health care costs may also involve social factors, but their expenditures are not as high as Americas. They do not have the same number of social problems that we have. But they have more problems than Sweden or Switzerland.

Looking at these other countries, we see that their drug offenses are relatively low and drug offenses lead to violence. And as you can see from chart 5, America leads everybody in the dubious distinction of having more homicides and more serious assaults, they end up in our emergency rooms, and in our intensive care units. They require intensive and expensive health care.

Now how are we getting at the drug problem?

Senator RIEGLE. Could I just ask you a question as we speed by here?

Dr. SCHWARTZ. Sure.

Senator RIEGLE. On your chart, violence, 1988, you look at the homicides in Britain, which is quite low; the number of serious assaults, they are actually second. Is that the difference with guns and no guns?

Dr. SCHWARTZ. I would suspect. I just do not know.

Senator BRADLEY. The figure on guns is that there were last year 14,500 murders in the United States with guns. In Canada it was 186.

Senator RIEGLE. But it is interesting you get such a sharp dichotomy here with Britain on the homicides.

Senator BRADLEY. Britain is lower than 190.

Senator RIEGLE. I understand. But when you look, they are second in rank on the serious assaults. I think it is probably the absence of guns in the assaults.

Dr. SCHWARTZ. It looks like they injure them but they do not kill them.

Senator RIEGLE. Yes, exactly.

The CHAIRMAN. Could I make the point, I believe common law assault is defined as just simply threat.

Senator BRADLEY. Yes. And there is a large percent of those assaults at football games. [Laughter.]

The CHAIRMAN. Sure. That is right.

Dr. SCHWARTZ. To take this drug problem a bit further, new data which we have received from Lewin & Associates indicates that last year we spent $6.7 billion on treatment of substance abuse—chart 6. The Legal Action Center estimates that next year—if we are to cope with this problem—we should spend $19 billion on rehabilitation alone.

That is a tremendous amount of money. But, you know, we speak about billions now and I think we lose sight of what it means to working people—chart 7. So what we did was, we took that $19 billion and determined what it would cost in Federal income taxes to an individual.

What you find is that the average American taxpayer pays about $5,000 in Federal income tax. If you then divide the $19 billion by $5,000, it would mean that 3.8 million taxpayers would have to

spend the equivalent of all of their Federal income taxes just to pay for the rehabilitation of these drug addicts.

And if we add the $300 billion, agreeing with the $300 billion estimate which Secretary Sullivan has used. Divide that by $5,000, we would have 60 million people in this country paying the equivalent of all the Federal income taxes just to pay for the medical consequences of our social problems.

So we see that the money is being transferred from people who are working to others who are not. This is a big problem in this country. One of the problems is, we have difficulty spreading the risk. In other countries, 95 percent of the people pay for the 5 percent who cannot pay. In this country it is about 65 percent who have to pay for 35 percent in addition to paying for themselves. They are paying for those who are in poverty and those who are medically indigent.

The next chart shows—chart 8—that the $900 billion spent for health care, most of it comes from 180 million working people and their dependents. The money is paid through private insurance, out-of-pocket, cost shift, and taxes. Most of it goes to two groups—Medicaid and Medicare recipients.

They receive about $600 billion of the $900 billion in medical care. That leaves $300 billion to pay the health care costs of the 180 million who have paid about $750 billion of the total health care bill. That is what we are up against.

In conclusion, I just want to read this quote which I think will show that the administration is very cognizant of this.

> "We must face the biggest part of the deficit and perhaps the biggest human dilemma that America faces—the health care crisis. We should be spending more for a number of reasons. We are spending quite a bit, but we should be spending more for a number of reasons.
>
> "Number one, we do more work on medical research. Number two, we rely on more and better medical technologies. And number three, we have a more diverse population with more poor people than most other advanced countries, more cases of AIDS than most other countries, and we are a more violent country than any other advanced countries.
>
> "So we pay more money to keep emergency rooms open on the weekend for people getting shot and cut up. We cannot get our costs down to the level of other nations unless we make changes dealing with these big structural things."

That was the President who gave that speech a couple of months ago and he certainly knows what is going on there.

The CHAIRMAN. Thank you very much, Dr. Schwartz. Thank you all.

[The prepared statement of Dr. Schwartz appears in the appendix.]

The CHAIRMAN. I think, Senator Riegle, you have not had a chance to ask any questions yet today or make any statement. You have been chairing your Committee on Banking.

OPENING STATEMENT OF HON. DONALD W. RIEGLE, JR., A U.S. SENATOR FROM MICHIGAN

Senator RIEGLE. Thank you very much, Mr. Chairman. We reported out an important housing bill up in the Banking Committee today and that did detain me.

I want to thank all of you for what you said here today in highlighting an important and sort of different light on these problems.

I would just make two observations. I was recently in Grand Rapids, MI. Grand Rapids, as an urban center is a pretty civilized place. It was the home Congressional district of Gerald Ford for over a quarter of a century.

They have a marvelous hospital there—the Butterworth Hospital. They have just finished building a state-of-the-art trauma center, which is probably as fine and up-to-the-minute as any opened within the last 6 months in the world. And you come in there with a bullet wound or whatever the problem is out of a car wreck and you can be X-rayed on the spot. You can get all of the advanced science applied in a life-saving mode immediately.

They were showing me all this and it was like going into the future and seeing all of this marvelous technology. Then they described to me that the last thing they had to purchase were two trained attack dogs from a kennel in Wisconsin that had to be purchased and brought to the hospital to be on duty to protect the doctors who were trying to deal with people who had come in and been shot in a drug fracas or whatever it was.

And in order to administer this life-saving care and to keep the doctors safe on the weekends, they had to have these dogs on duty because people who tried to shoot somebody and did not get the job done would then come to the hospital to try to finish the job while the physicians were in the trauma center trying to fish out the bullets and save somebody.

So they actually had to invest in these two trained attack dogs to protect the medical personnel who were trying to save these lives.

Now this sounds like Clockwork Orange and in effect it is. But this is Grand Rapids, MI. It is real and, it is today, more and more, the order of the day. But to me it sort of laced together these two propositions of this tremendous rush of science and medical skill and capability to save lives and at the same time this sort of violence which is spiraling to such a degree that, you know, they are coming together literally right in the very same setting.

The other thing was an experience I had yesterday in Owaso, MI where I met with a group of women who had lost their jobs in a wire harness factory that closed and went to Mexico in 1990. As they told me their personal stories, they were reduced to tears, I was reduced to tear, I mean, about the abject poverty of the circumstance that is affecting working parents, single mothers, many others who were there.

One woman particularly, who has not been able to get and pay for regular medical exams for the last 10 years or so because she has needed the money to put clothes on her kids and pay the electric bill and keep the rent payments up-to-date so she is not put out into the streets, driving an old rattle-trap car; and she has just found that she now has a serious health problem that is going to require surgery and it may or may not be something she can survive.

But I was so struck by just the terrible human tragedy of the fact that we have not been attentive. She has not been able to earn enough or be able to do this. They made this comment, Mr. Chairman—and I will just stop with this because we have been given a lot to absorb here today.

She made the comment that she does not buy anything new. The thought of buying a new car, or a new house, or a new dress or a new anything is just out of the question. This is one of the reasons why yard sales have cropped up and are so prevalent in States like mine because there are so many people that have been sliding backward.

She says she never buys anything that has not been marked down twice if she goes to a K-Mart or somewhere. A very intelligent, very tough woman, does not want to be on welfare, does not want to be on public assistant, loves her kids, wants to take care of her kids. This kind of assault on working people and people in our society who are not able to get the help they need in a preventive care sense, in a systematic way, it is just—we are sort of brutalizing ourselves as a nation.

That is sort of separate and apart from the kinds of social disorder and crime and so forth we are talking about. But this is a different kind of a crime. This is a crime of a system that is so unthinking that it allows its people to suffer needlessly and ends up paying more later because we have not had the good sense to establish a social policy and a health regime to get people on a regular healthy life track coming down the road.

But having sat with six mothers yesterday who all are working like dogs, now in many cases working two and three minimum wage jobs, they are working 80 hours a week, driving these old beat-up cars, trying to just sort of stay one step ahead of the next bill that is coming and talking about their kids having to babysit the younger children and sort of foregoing their youth, if we do not use this occasion to figure out how to do this right, Mr. Chairman, it is going to take a lot more of social science.

I appreciate so much the fact that you have scheduled this hearing because this is not just a mechanical exercise. It is sort of rewiring the control panel. I mean, we have to think through and be wise enough to figure out how we stop some of these trend lines that are bankrupting us and killing our people at the same time.

The CHAIRMAN. Thank you, Senator Riegle.

Senator Grassley?

Senator GRASSLEY. I think I want ask Dr. Schwartz a question. I think it would be most appropriate. If others want to answer, it is okay.

The CHAIRMAN. Please, anybody who wants to comment, just do.

Senator GRASSLEY. What do we really know about the quality of health care in other countries? In the United States, we are just getting into this effort of trying to accurately measure outcomes in the quality of care. Is there anything like what we are just starting to do in America in either Europe or Canada? And if not, how can we compare the quality of care in these different countries, particularly if we factor out the social problem dimensions and do not look at the health status indicators?

As I indicated to you in my opening statement that the Office of Technology Assessment concluded that health States indicators might not be very helpful in telling us anything about the health care system.

Dr. SCHWARTZ. Well, I would say that we have traditionally used health status indicators as surrogates for health care outcomes. In-

fant mortality and life expectancy rates are the way we compare countries.

Senator GRASSLEY. Well, you are assuming then that if the statistics are better they have higher quality health care as opposed to how people live generally.

Dr. SCHWARTZ. Well, I do not think that the statistics are better. I can show you that here.

Senator GRASSLEY. No, I mean, I am not saying ours are better, but they are better in these other countries.

Dr. SCHWARTZ. No, they are not. I do not think they are better.

Senator GRASSLEY. Oh, okay.

Dr. SCHWARTZ. I want to give you an example of that. These are the best infant mortality rates by country, as you can see, about the top 15 countries. The United States has a higher infant mortality rates, which actually would say that we are not doing as well.

However, when you start comparing the countries with our individual States, a different picture emerges. In fact, many of our States show that they are doing as well as most of the other countries with better infant mortality rates.

In fact, half of the States in the United States have infant mortality rates which fit them in with the best 15 in the world. Which, in fact, shows that the demographics of the States vary tremendously: You barely see any southern States in there at all.

The CHAIRMAN. Could we get that table? We do not have it.

Dr. SCHWARTZ. Yes, sir.

[The table appears in the appendix.]

Dr. SCHWARTZ. Basically, what it shows is that some States are doing very well, but other States are doing very poorly with the same health care system. But socioeconomics differ by State and population differs by State and, therefore, infant mortality differs by State.

So I think it is really wrong to compare country to country. The same thing applies to Canada. If you go by province you will find that they vary two to one in infant mortality from province to province. The same thing applies to life expectancy.

What has happened in this debate is that we have not looked very closely at other countries. Another factor is that America is doing very well when it comes to medical and surgical interventions. But, in fact, we are doing better than most other countries for things like heart attacks, prostate hyperplasia, and cervical cancer. We have very good mortality rates for these conditions.

The World Health Organization publishes these data every couple of years so that we can compare the United States with other countries in terms of the health care system as well as the social system, and there we are doing very well.

Senator GRASSLEY. I think you are telling me in both foreign countries as well as the United States we do have a way of measuring quality.

Dr. SCHWARTZ. Yes, sir.

Senator GRASSLEY. And doing it effectively so that the comparisons are legitimate.

Dr. SCHWARTZ. Yes, I think you can show that the quality of American health care for most people is very high and, of course,

the thing we would like to do is spread it to everybody. I think that we can show that factually.

The CHAIRMAN. Well, Senator Grassley, if you do not mind, I think we would just like to let Senator Bradley make a comment.

Senator GRASSLEY. I can submit some questions for the record.

The CHAIRMAN. Would you do that?

Senator GRASSLEY. Yes.

[The questions appear in the appendix.]

Senator GRASSLEY. Besides, I am hungry, too. [Laughter.]

The CHAIRMAN. Senator Bradley?

Senator BRADLEY. Mr. Chairman, let me first of all thank you for having this hearing. This has been really an extremely enlightening hearing. It is one of those moments where the shade comes down and you see something that has always been talked about in other contexts, but never measured so precisely in terms of health affects, in terms of costs.

I am sure that there are people who would dispute some of these numbers, but overall let us assume these numbers are correct. You have $121 billion from the medicalization of social problems.

My guess is that your numbers of violence costing $5.3 billion would be significantly lower than Dr. Miller's estimates on the costs of violence. I would consider it to be relatively low compared to some of the things that Dr. Miller was saying.

My question to you is now, we are the Finance Committee. We see these figures, let us say that we can agree on a rough number. The issue is how to decrease these costs in the course of which, how do you decrease the behavior that produces these costs.

We have taxes at our hands, at our fingertips. Now what if we dramatically increased the taxes? You cannot do it on all of these, obviously, or maybe you can and I have not thought of how yet. But do you think that some of this behavior would be responsive to much higher taxation to try to include the social costs of the behavior?

Now clearly we have seen smoking drop in consumption. We want to try to apply that as best we can to violence in terms of gun violence, in terms of ammunition and handguns and assault weapons. But can you carry us forward in your assessment as to whether this would have a significant affect on the incidence of this behavior?

The CHAIRMAN. Why doesn't each of you respond in turn? I would particularly like to point out that Lee Rainwater is the Research Director of the Luxembourg Income Study, which is the first international effort of its kind. So we can bring in the European perspective. Why don't we just go right across the way? Dr. Miller?

Dr. MILLER. I think that certainly you can find some experience that way. We know from a number of academic studies that if we increase the taxes on alcohol and on beer in particular that we will see a drop in drinking, that drop in drinking will be associated with a drop in domestic violence, it will be associated with a drop in drunk driving.

We have seen certainly the evidence of smoking. I think with guns we know that if we can get less guns and ammunition out there, we will see drops in homicide and suicide and in attempts. So I think that heavy taxes would certainly reduce that.

There is a subelement within that of people who are going to get them anyway, particularly in the drug industry. I think at this point the money flowing through there and the cost of entry in the drug industry right now, which many low-income urban youth see as one of the few readily available avenues into the middle class.

The price of entry to that avenue——

The CHAIRMAN. No, no, doctor. Nobody ever got into the middle class dealing in drugs.

Dr. MILLER. According to studies——

The CHAIRMAN. It only gets you into an early grave.

Dr. MILLER. You have a good risk of the early grave. But until you get to that early grave, according to Peter Reuter's work at the Rand Corporation, you are going to make about $30,000 a year.

The CHAIRMAN. Yes, and you blow it. Another time. I did not want to interrupt you.

Dr. MILLER. I think what I would say though is that to a low-income person, being able to make $30,000 a year looks very good and they sometimes look the other way on the violence.

The CHAIRMAN. There is a heavy counting of gratification.

Dr. MILLER. Agreed.

The CHAIRMAN. We know that.

Senator BRADLEY. Anybody else?

The CHAIRMAN. No, next, Dr. Rainwater. You cannot avoid this question, sir. Senator Bradley wants your answer.

Dr. RAINWATER. I am not sure I have anything really to say about the affect of taxes on these kinds of issues.

The CHAIRMAN. Do your studies in Europe suggest different behaviors by different tax regimes or are the regimes tending to get homogeneous now?

Dr. RAINWATER. No, the taxes are different, particularly on alcohol and cigarettes. People from Britain are buying their beer in France now because it is a lot cheaper and they can afford to take it back. It is no longer illegal to take it back since the treaty of 1993 went through.

I think countries differ enormously in their use of these things like tobacco and alcohol and so on. And to a certain extent, each country has its own cultural mix on that, and how taxes will act on that will be different from one country to another.

The CHAIRMAN. But no country that you know in Europe has anything like the disorders we have been seeing that Dr. Schwartz described as pathology flowing in?

Dr. RAINWATER. Oh, certainly not.

The CHAIRMAN. Certainly not.

Dr. Farley?

Dr. FARLEY. There is the question of the social pathologies we have been talking about today, what kind of consensus can be reached by our society about eliminating them. We have had about 30 years of evidence piling up gradually and then becoming more convincing about the deleterious consequences of smoking and there taxes can go hand-in-hand with a growing awareness of the consequences of tobacco consumption.

It seems to me it is more challenging with regard to alcohol since the overwhelming majority of people who drink do not abuse alco-

hol. But there is this larger question of how does our society decide what things to condemn very severely and what things to tolerate.

We have had lots of changes over time. We have hopes now that the violence which leads to homicides through guns will be reduced by a variety of strategies.

The CHAIRMAN. How? What hope? When you get this proportion of urban males raised in single-parent families, what hope have you, Reynolds Farley?

Dr. FARLEY. I would think if you can reduce access to guns you are going to reduce a substantial fraction of that violence. But at that same time, one would hope that there would be a greater awareness of how to handle aggression without it leading to violence.

We have some small pilot programs working on that, but there is very little developing in that nature.

The CHAIRMAN. I did not mean it to be anything more than to say, we have not found anything yet. Have we?

Dr. FARLEY. That is right.

Dr. SCHWARTZ. I do think that is a question of taxes. We have been raising them and spending a tremendous amount of money. But I think a reallocation is appropriate: Putting the social causes into a different ledger and paying for them in a different way. If $300 billion of health care costs is what is caused initially by social problems, I think these costs should go into a social ledger and not into the health care ledger.

If you do that, then we will not be pushing to totally change the health care system. We will make the reforms, which it certainly needs. But we will be spending $630 billion instead of $930 billion and we will be spending $300 billion in another ledger as the Europeans do.

I think that if we do that we remove an awful lot of the medicalization, which is very high cost and may not attack the problem. If we did it that way, social policy will be attacked by social workers who know this area rather than doctors who may not know it, but get to deal with it anyway.

I think that it would cost the same amount of money.

Senator BRADLEY. If I could on that point, I understand that $300 billion of the current health expenditures you have put in is medicalization of social cost. Right?

Dr. SCHWARTZ. Well, all of it——

Senator BRADLEY. But the fact still remains that there are people this year that are going to get lung cancer because they have smoked for 30 years. There are people who are going to get shot this year because you only have to pay $10 to get a dealership license to sell guns to kids.

You know, there has got to be some revenue from somewhere and it has to pay for the health budget. Are you just talking about an accounting procedure?

Dr. SCHWARTZ. No. As a matter of fact, I think this is a health care system that is going to last a couple of hundred years, not just tomorrow and the day after. So I think that we should be very deliberate in making any changes, the outcome of which we are not sure what it will be.

Senator BRADLEY. You see, the traditional arguments against taxation of the variety that we are talking about is that—one of them—it is regressive. It is harder. In fact, I have even had people argue with me on the ammunition and gun tax that, gee, this is unfair because the poor will not be able to get their guns.

Well, it seems to me that what you are doing is, if you are able to decrease the incidence of the activity, you are extending their lives. So there is some compensation for the unfairness.

Then, as you say, if you use some of that revenue to deal with some of the underlying causes, you have a better opportunity.

But the other thought that occurs to me, frankly, Mr. Chairman, is, you know, we have kind of turned us all into a nation of victims. We are all victims of something.

The CHAIRMAN. We are into that.

Senator BRADLEY. And medicalization of these behavioral costs is a very good example of the victimization syndrome. When, in fact, it is a matter of someone saying no, either because the price is too high because you put on taxes or some other kind of activity then you are taking personal responsibility for your own behavior, it seems to me.

Dr. SCHWARTZ. But if you add taxes, the same people who are paying for the health care system today are going to pay the taxes because there is nobody else to pay it. In fact, we have such a large population of poor people that in the end the money will come from the same people. You can transfer it over.

The CHAIRMAN. We might surprise ourselves. But anyway I think Senator Bradley has in mind taxes in certain areas being used to discourage activity, so when the revenue reaches zero you would have achieved your purpose. [Laughter.]

Senator GRASSLEY. It seems to me that if his goal is to get at the root causes, it does not get at the tap of root causes, which is the violence you see on television. You do not tax television, discourage——

Senator BRADLEY. I have a bill for you to co-sponsor on that. [Laughter.]

Senator GRASSLEY. What?

Senator BRADLEY. I have a bill for you to co-sponsor on that.

The CHAIRMAN. I think at this point, with the hour of 1:00 p.m. having arrived, you have been a wonderful panel. It has been thoroughly helpful. We hope we can call on you. I know that Dr. Rainwater is at this very minute rushing off to Paris or to Luxembourg.

We again want to thank you both very much especially, doctors all.

Dr. SCHWARTZ. Thank you very much.

The CHAIRMAN. We are adjourned.

[Whereupon, at 12:55 p.m., the hearing was adjourned.]

APPENDIX

Additional Material Submitted

Prepared Statement of Senator John H. Chafee

Mr. Chairman, I am pleased that the Finance Committee is continuing this series of hearings on the need for health care reform. Changing the health care system will prove to be one an arduous and dramatic policy undertaking. If we are successful, we will see the changes in just about every aspect of American life.

I am one who believes that is possible to put political partisanship aside to develop a sensible health reform package that will meet the needs of our nation. But we would do well to remember what a massive, all encompassing undertaking reform is.

Today's hearing on the social problems and their costs is one important ingredient to understanding the underlying causes of rising health care costs. Hardly anyone disputes that the U.S. health care system is wasteful and managerially backward. But the taxpayer also pays a price for society's problems. There is a burden imposed on the health care system. The Federal government pays to support numerous drug and substance abuse programs, maternal and child health programs and other health services programs to cure the ills caused by poverty or unhealthy behavior. Gun violence, particularly handgun violence, costs our nation billions of dollars every year, most of which is paid by the government.

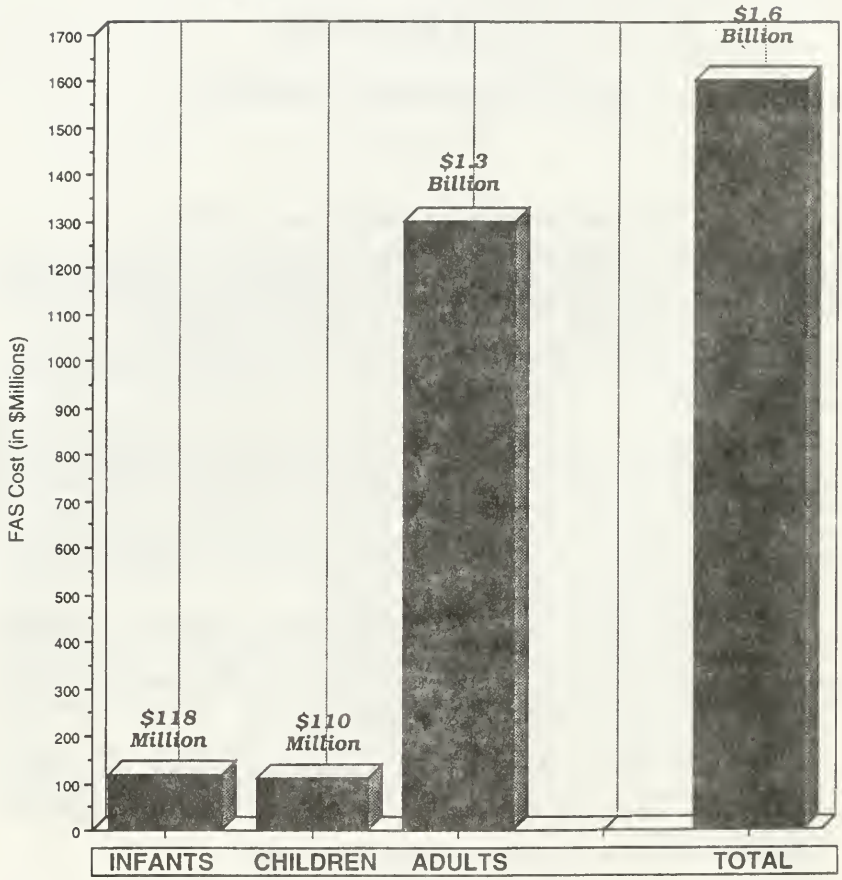
Because of the mounting burden on the American taxpayer, we have an obligation to examine what we can do. But we must not forget that we also owe an obligation to help those that need it most. Simply identifying a problem does not solve our dilemma. We must also find out if society is willing to pay the social consequences, both indented and unintended, of the solution. If not, then will have to find more efficient or more effective ways to pay the health care costs.

The health care crisis can be viewed as an economic crisis, on par in gravity with the crushing federal budget deficit. However, we must also remember the people we will affect in trying to reform our health care system. We cannot degrade its quality. We also should not further limit access to the system or dismember programs to those most in need.

I look forward to hearing today's testimony on this issue.

[Submitted by Senator Tom Daschle]

THE LIFELONG COST OF FETAL ALCOHOL SYNDROME (FAS)

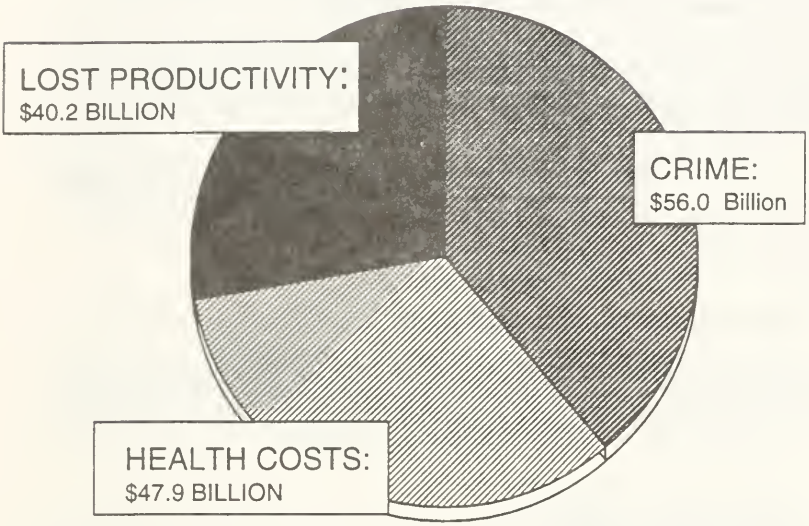


The Lifelong Cost of FAS:

- For INFANTS, neonatal intensive care costs the U.S. $118 million per year.
- Residential care for mentally retarded CHILDREN with FAS adds another $110 million.
- Finally, rehabilitation services and residential care for ADULTS with FAS costs Americans $1.3 billion per year.

With other miscellaneous costs factored in, the bill for FAS comes to a staggering $1.6 BILLION each year.

Substance Abuse Costs the U.S. over $144 Billion Each Year



Source: Alcohol, Drug Abuse and Mental Health Administration

Property destruction, law enforcement, auto crashes, premature deaths, health care costs, treatment costs, AIDS, FAS and lost productivity – the $144 billion price we pay for alcohol and drug abuse.

Births to Unmarried Women: Turning Points in the 1960s and 1980s

In 1991, a record high 30 percent of the nation's 4.1 million births were delivered by unmarried women, a substantial shift from the 5 percent figure recorded fifty years ago. During World War II and for almost two decades thereafter, there was little change in the proportion of births occurring to women without husbands although there was a large racial difference as shown in Figure 1. Until the 1960s, the percent of white births to unmarried women hovered around 2 percent while among blacks it was consistenly about 18 percent.

Shortly after 1960, the percent of births to unmarried women began to rise. In 1969, for the first time, one birth in ten occurred to a woman without a husband; by 1983 it increased to one in four and, by the middle of this decade, it will be one in three unless a firmly established trend is overturned.

The rise has been sharper among blacks than among whites. By the late 1960s, about one African-American child in three was born to an unmarried woman and, since 1976, the majority of black babies had unmarried mothers. Today, two of three black births are in this status. The proportion to unmarried mothers among whites now - 22 percent - is approximately what it was among blacks in the early 1960s.

Childbearing by Married and Unmarried Women

At first glance one might think that the sharp rise in the proportion of births occurring to unmarried women reflects much higher rates of childbearing by women before they marry or after their marriage ended. This is not an appropriate conclusion. The percent of total births occurring to unmarried women is determined by three factors:

a) the birth rates of married women
b) the birth rates of unmaarried women
c) the percent of women married

To telegraph a conclusion, let me report that the rise in the proportion of births to unmarried women after 1960 was primarily attributable to the rapid fall in marital birth rates and to the shift toward later ages at marriage. The rise in the proportion occurring to unmarried women in the 1980s is different since it is driven by higher birth rates for unmarried women as well as the continuing trend toward much later marriage.

Figure 2 shows births per 1000 married and per 1000 unmarried women ages 15 to 44 for the post-World War II era. The baby boom of the 1950s is evident along with the baby bust that followed. Childbearing by married women became much less frequent in the 1960s and early 1970s. The fall was more rapid among married black women than whites and, for almost twenty years, black married women have borne children at a lower rate than white married women.

Fertility rates of unmarried women did not fall so rapidly during the birth death years of the 1960s and 1970s. Among whites they held constant and, each year, about 1 percent of unmarried white women 15 to 44 became a mother. Among unmarried black women, childbearing declined. At its peak in 1960, 10 percent of unmarried black women bore children each year but this fell to about 7 percent in the early 1980s.

A new pattern developed within the last ten years: increasing fertility rates among women of both races. The rate at which unmarried white women 15 to 44 became mothers doubled in the 1980s and, among blacks, this rate rose so precepitiously that by the later 1980s unmarried black women 15 to 44 had a higher birth rate than married black women.

Figure 3 provides additional information by showing the birth rates of married and unmarried women at peak childbearing ages. The rising fertility rates of unmarried women during the 1980s are evident.

Trends in Marital Status: The New Pattern of Delaying Marriage

The pervasive and continuing trend toward later marriage is one of the more dramatic demographic changes of recent decades. The Census of 1960 clearly described the patterns of that era: women typical married within a few years of high school graduation and almost all men became husbands before age 25. That enumeration reported that about three out of four women 20 to 24 were wives. By 1990, that fell to about one women in three. In 1960, 80 percent of the men 25 to 29 were husbands but the Census of 1990 found this was down to 55 percent. Figure 4 shows the proportion of people in young age groups married throughout the last half century. The shift toward older ages at marriage continues and may eventually result in record high proportion of people never marrying.

Accounting for Changes in the Proportion of Births Occurring to Unmarried Women

If married and unmarried women continue to bear children at the same rate as in the past but fewer women are married, the proprtion of total births to unmarried women will rise. Or, if the birth rate of married women goes down over time while that of unmarried women remains unchanged, a higher proportion of babies will have an unmarried mother. These, in fact, are the changes producing the higher proportion of births to unmarried women in the 1960s and 1970.

Table 1 shows the percent of total births occurring to unmarried women in 1970, 1980 and 1991; the most recent year for which data are available. Increases are decomposed into the following factors:

a) changes in the birth rates of married women
b) changes in the birth rates of unmarried women
c) changes in the percent of women 15 to 44 married

In the 1970s, the major cause of the increasing proportion of births occurring to unmarried women was the decline in the percent of both black and white women married. As a demographer would state it, women were increasingly at risk of unmarried childbearing and less at risk of becoming a married mother. Changes in marital birth rates in the 1970s also played a role since they fell much more than the birth rates of unmarried women.

Causal forces were different in the 1980s, especially among whites. The rising brith rates of unmarried women explain much of the rise although the continuing delay in marriage had an impact, more so among blacks than among whites. Among both races, marital fertility rates in 1991 were higher than in 1980, a change which, ceteris paribus, decreased the proportion of births occurring to unmarried women.

What Explains the Changes in Marital Status and Fertility Rates?

Why did the percent of births to unmarried women increase from 11 percent in 1970 to 30 percent in 1991? To account for this we must explain why young adults now marry at much older ages and why the birth rates of unmarried women - both white and black - started to go up in the mid-1980s.

Explanation for the delay of marriage focus upon two issues. One view stresses the declining economic fortunes of men who entered the job market after 1970. The earnings of young men have fallen, apparently since the mid-1970s, The investigations of Frank Levy and Robert Mare with recent census data report that the only men under age 35 who earned as much in 1990 as similarly aged men in 1980, were those who completed college. Young men are generally earning less - and have higher unemployment rates - than did young men ten or twenty years ago. As a result they may be unwilling to assume the responsibilities of marriage and may simultaneously be viewed by women as unable to provide the economic stability needed to form a family.

A very different view emphasizes upon the personal and economic independence of women. By the late 1960s, young women began to close the educational gap separating them from men. In the 1970s, women in large numbers started entering the professional schools once dominated by men. And the Census of 1980 reported that women were moving into job categories once reserved for men; especially in the lower level managerial ranks. Suzanne Bianchi's investigations utilizing the Census of 1990 demonstrate that young women made substanial progress in the 1980s in closing the gender gaps in occupational achievement and earnings. Opportunities for young women expanded at the same time the wages of young men fell. One outcome may be that women have fewer incentives to marry. And, indeed, some may increasingly prefer the personal indepedence sustained, to some degree, by the unusually large occupational and earnings gains of women in the 1980s.

If independence is a driving force leading to later ages at marriage for women, it may also encourage some women to bear a child even if they do not have a husband. Thirty years ago, bearing a child out of wedlock was considered such a deviant act that no national surveys asked people how they felt about it. Presumably everyone condemned such behavior. But, since 1974, national samples have been asked their attitudes about unmarried women having children and they reveal an unambiguous trend toward more liberal attitudes although most still disapprove. By 1985 about 48 percent of the adult population agreed that there was no reason why a single woman should not have a child. When brought closer to the respondent's own home, however; there was less approval. In 1985, only 14 percent of adult whites and 28 percent of blacks said that it would be acceptable for their unmarried daughter to have a child. (Pagnini and Rindfuss, 1993)

Interestingly, young college educated women express the greatest approval of unmarried childbearing. Given trends in education and the cohort replacement process, it is reasonable to expect a continued shift toward attitudes supporting childbearing by women who are not married. To use an inappropriate metaphor, attitudes are shifting toward approval of the uncoupling of marriage and childbearing.

The Implications of Unmarried Childbearing

Undoubtedly some, perhaps many, children born to unmarried women thrive. But, in the aggregate, such children are currently at a substantial risk of spending time in poverty, a poverty which is not fully mitigated by transfer payments from our welfare system or by payments for their fathers.

The census does not tabulate individuals by what was written on their birth certificate but provides crucial data relevant to these issues. Table 2 shows information about two contrasting groups of children under age 6. One consists of those living with their mother under age 40 in a husband-wife household; that is, their mother was co-head of their married couple household. The other group consists of children under age 6 living with their never married mother, under age 40, who headed her own household. Given the demographics of this situation, these children were recently born to an unmarried woman.

If we consider the New York metropolitan area in 1990, we find that 10 percent of the children in married couple families lived in poverty based upon their household's pre-tax cash income in 1989. Among children under age 6 living in households headed by their never married mother, two-thirds were impoverished. We might consider the other end of the income distribution and define as affluent those prosperous households whose income exceeded five times the poverty line for their size; that is, an income in excess of $52,000 for a household of size four. Twenty-eight percent of New York's children under age 6 living with their mother in a husband-wife family could be termed affluent in contrast to only 1 percent of those living with their never married mother.

At the base of Table 2 are census reports of the average AFDC and general assistance payments reported for 1989 by those never married women who headed their own household which included one or more children under age 6. The census counted about 55,000 such households in New York in 1990. They reported an average of $ 2150 in cash transfer payments from AFDC and general assistance. Despite this, two-thirds of these households were impoverished.

Conclusion

The proportion of births occurring to unmarried women changed little from 1940 to the early 1960s but then began to rise, an increase continuing to the present. The early shift toward highly levels was largely attributable to the rapid fall of marital birth rates and the shift toward later marriage. The driving forces behind the rising proportion of births occurring to unmarried women in the 1980 are different. While the continuing tendency to put off marriage plays an important role, the birth rates of unmarried white and black women have risen throughout the last decade. Shifts in attitudes imply that our norms may no longer abjure childbearing by unmarried women.

Citation

Pagnini, Deanna L. and Ronald R. Rindfuss
1993 "The Divorce of Marriage and Childbearing: Changing Attitudes and Behavior in the United States," Population and Development Review, Vol. 19, No. 2 (June), Pp. 331-348.

FIGURE 1. Percent of Births Occurring to Unmarried Women, 1940 to 1991, by Race

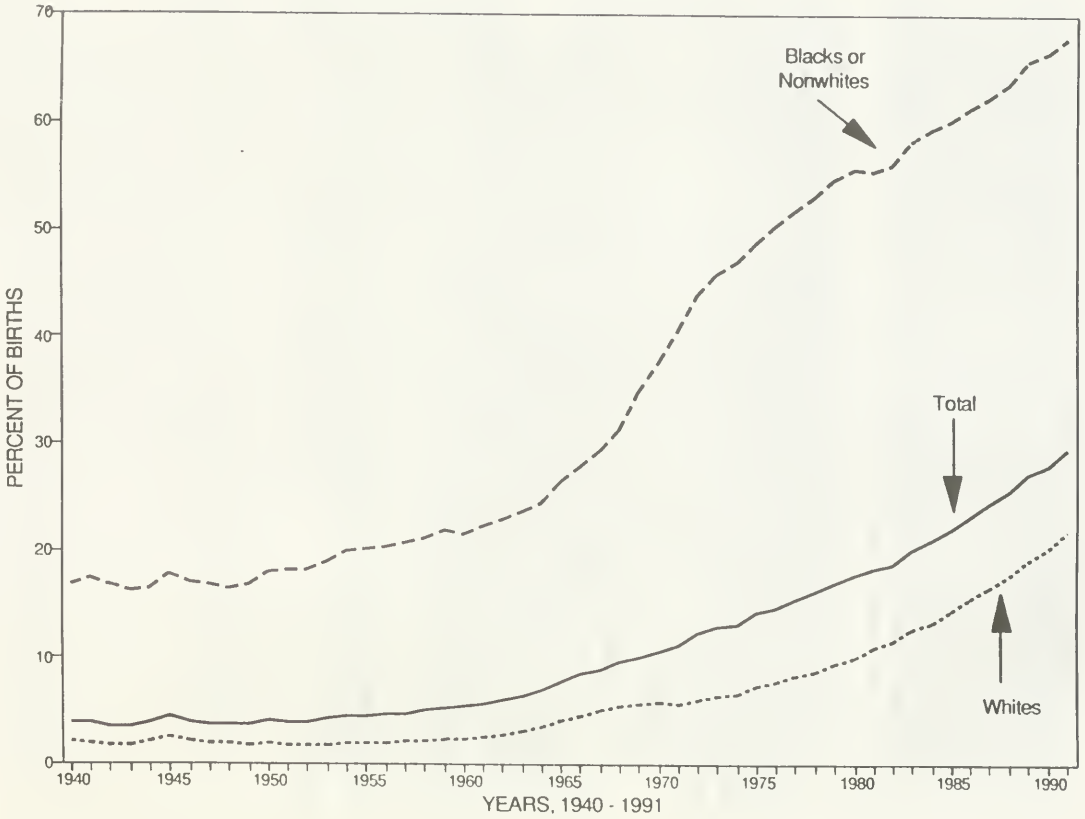
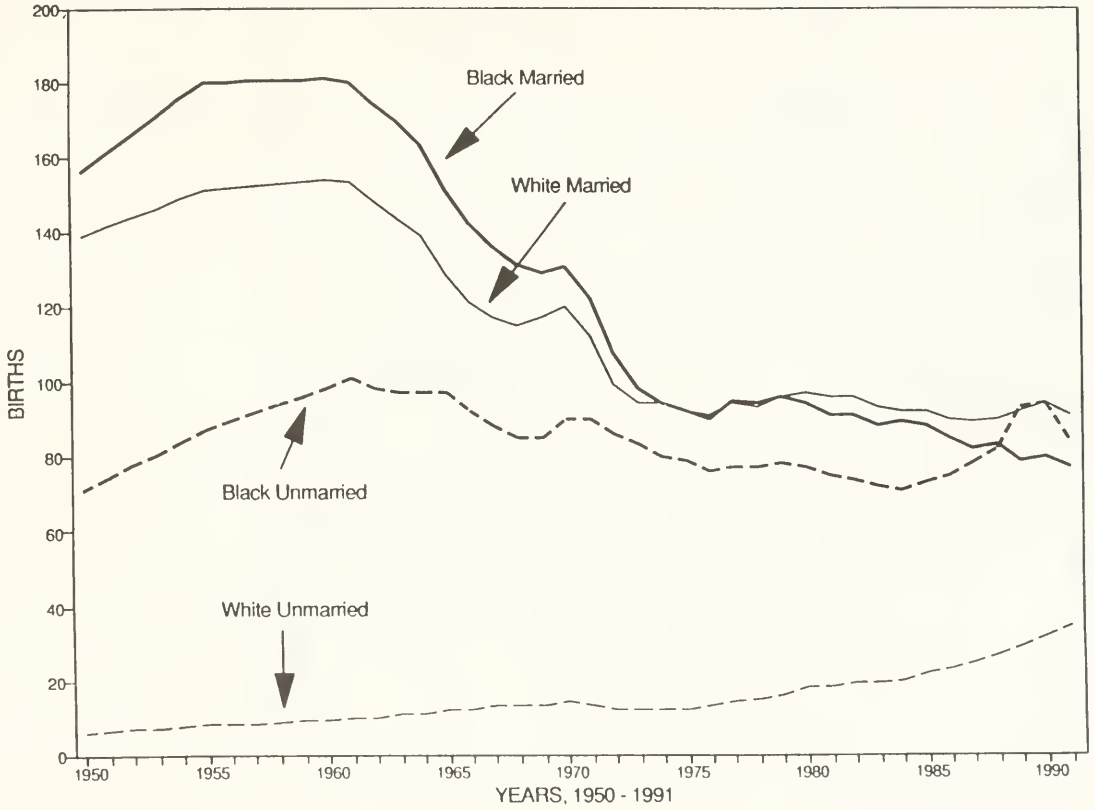


FIGURE 2. Birth Rates Per 1,000 Women Aged 15 to 44, by Marital Status; Blacks and Whites



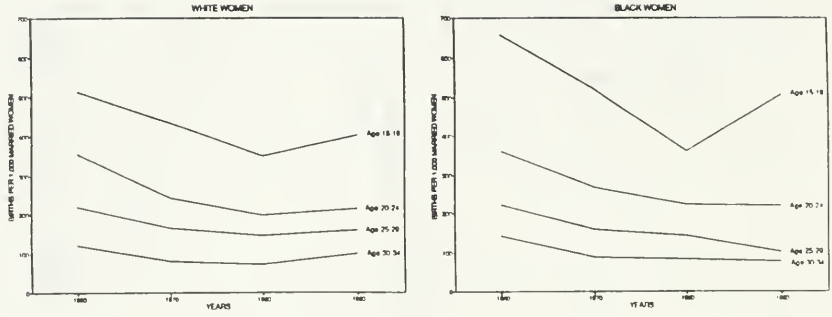


FIGURE 3 Births Per 1,000 Unmarried Women, by Age, Blacks and Whites, 1960 to 1990

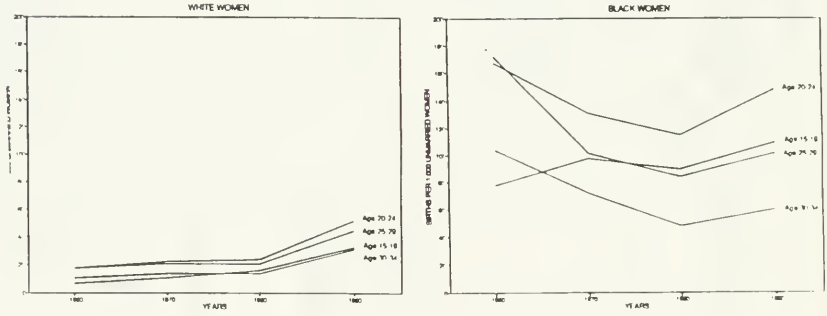


FIGURE 4. Percent of Young Men and Women Ever Married; 1940 to 1990

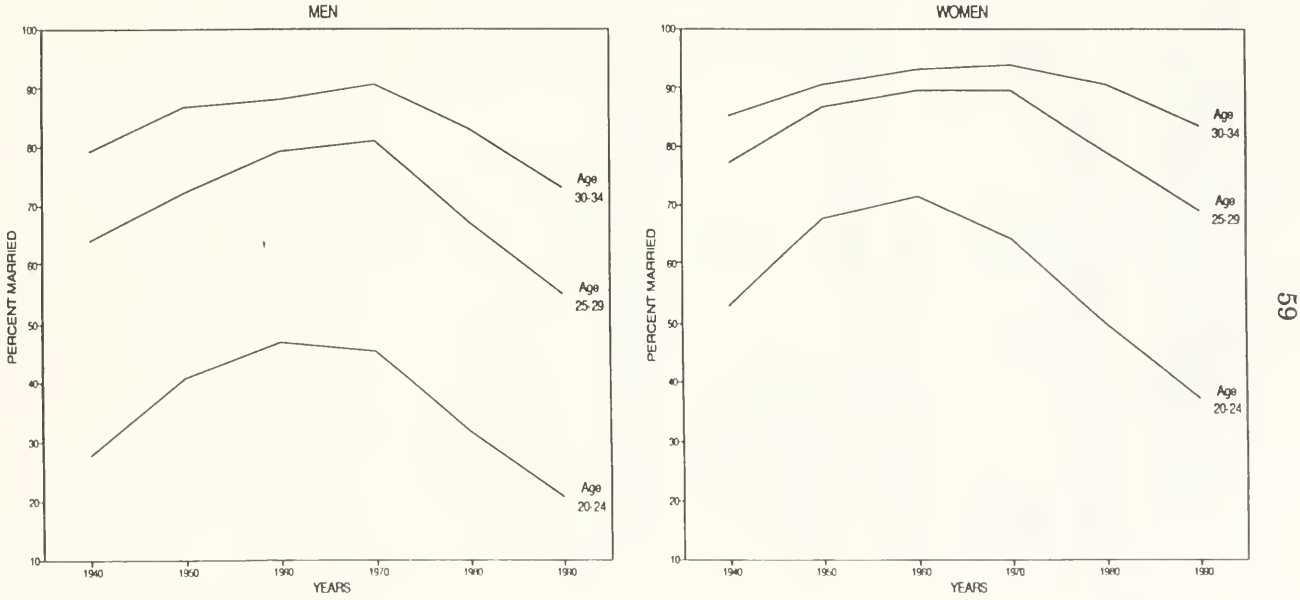


Table 1

Components of Change in Percent of Births Occurring to Unmarried Women; 1970 to 1980 and 1980 to 1991

Percent of Births Delivered by Unmarried Women

Year	White	Black
1970	5.7 %	37.6 %
1980	11.4 %	55.3 %
1991	21.8 %	67.9 %

Components of Change: 1970 to 1980

	White	Black
Total Change	+ 5.7	+ 17.7
Change Attributable to:		
Marital birth rates	+ 1.1	+ 5.5
Non-marital birth rates	+ 1.0	- 3.8
Percent of women married	+ 2.9	+ 17.1

Components of Change: 1980 to 1991

	White	Black
Total Change	+ 10.4	+ 12.6
Change Attributable to:		
Marital birth rates	- 1.8	- 1.6
Non-marital birth rates	+ 9.3	+ 4.9
Percent of women married	+ 3.8	+ 11.9

Table 2

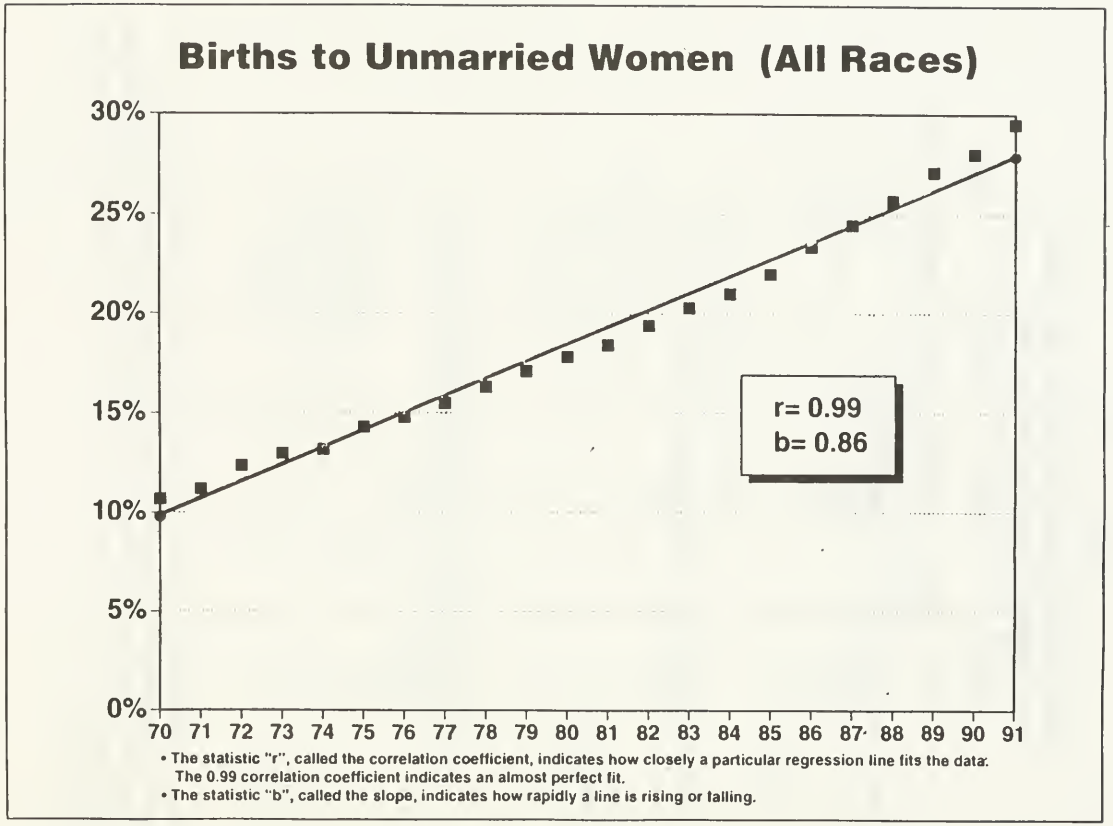
Economic Status of Children Under Age 6 in 1990 by Family Living Arrangements; United States and New York

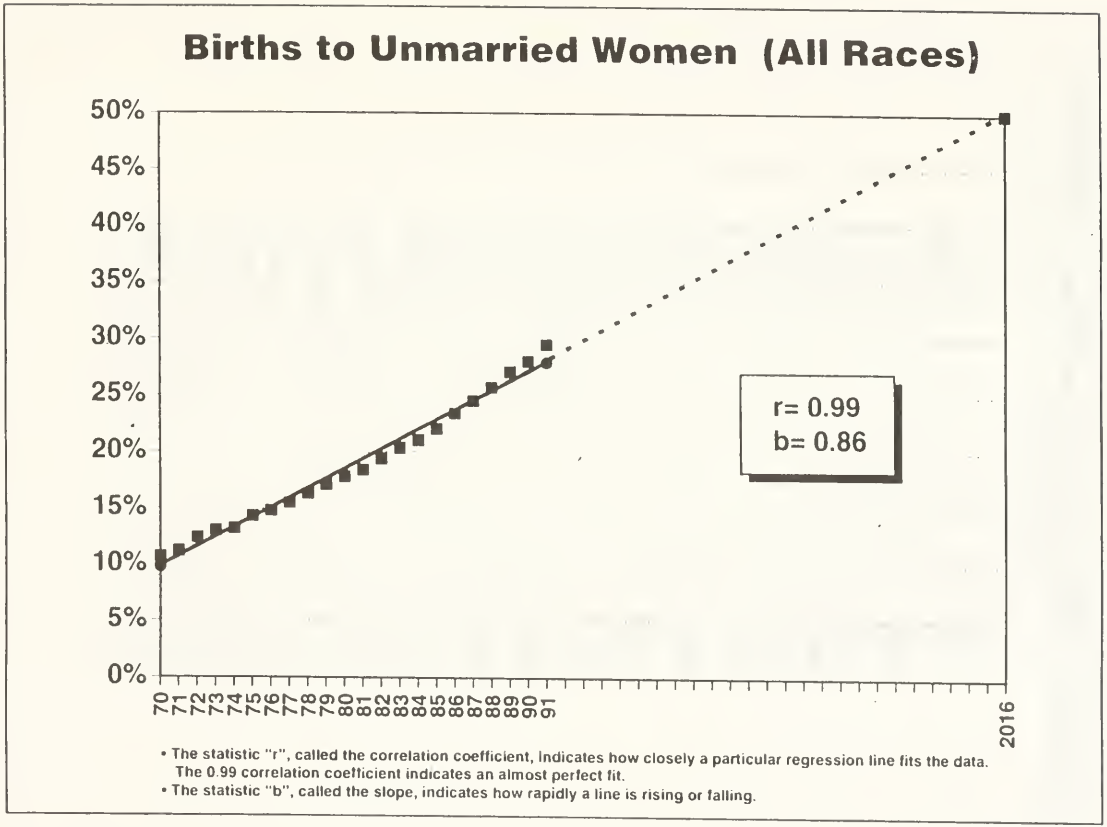
	Total		White		Black		Latino	
	Poor	Affluent	Poor	Affluent	Poor	Affluent	Poor	Affluent
Children Living with Mother in Husband-Wife Family								
U. S. A.	9%	17%	7%	18%	14%	10%	21%	7%
New York Metro	10	28	7	.34	14	16	19	10
Children Living with Never Married Mother in Household She Heads								
U. S. A.	72%	<1%	65%	1%	75%	<1%	74%	<1%
New York Metro	67	1	65	4	61	<1	74	2

Average General Assistance and AFDC Payments in 1989 to Households Headed by Never Married Women with Child of Children Under Age 6

	Total	White	Black	Latino
U. S. A.	$ 1923	$ 1781	$ 1893	$ 1835
New York Metro	2147	3148	1605	2812

Note: These data refer to children under age 6 living with a mother aged 15 to 39. Poor refers to households with pre-tax cash incomes in 1989 less than the poverty line for households of their size. Affluent refers to households with incomes five or more times the poverty line for households of their size. Date refer to the New York Primary Metropolitan Statistical Area:


Births to Unmarried Women (All Races)
30%
25%
20%
15%
10%
5%
0%
70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91
r= 0.99
b= 0.86
• The statistic "r", called the correlation coefficient, indicates how closely a particular regression line fits the data. The 0.99 correlation coefficient indicates an almost perfect fit.
• The statistic "b", called the slope, indicates how rapidly a line is rising or falling.
Births #4


Births to Unmarried Women (All Races)
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
70
71
72
73
74
75
76
77
78
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90
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2016
r= 0.99
b= 0.86
• The statistic "r", called the correlation coefficient, Indicates how closely a particular regression line fits the data. The 0.99 correlation coefficient indicates an almost perfect fit.
• The statistic "b", called the slope, indicates how rapidly a line is rising or falling.
BirthtoUnmarried Woman(2016)#4

Percent of Births to Unmarried Women (All Races)

1970	10.7
1971	11.2
1972	12.4
1973	13.0
1974	13.2
1975	14.3
1976	14.8
1977	15.5
1978	16.3
1979	17.1
1980	17.8
1981	18.4
1982	19.4
1983	20.3
1984	21.0
1985	22.0
1986	23.4
1987	24.5
1988	25.7
1989	27.1
1990	28.0
1991	29.5

Percent of Births to Unmarried Women 1991 (All Races)

Atlanta	64.4
Baltimore	62.1
Boston	47.3
Chicago	54.7
Cleveland	64.1
Dallas	34.6
Denver	38.4
Detroit	71.0
Houston	26.2
Kansas City	46.2
Los Angeles	47.9
Miami	51.2
Minneapolis	45.7
Newark	64.7
New York City	45.2
Philadelphia	59.4
Pittsburgh	51.9
St. Louis	65.9
San Francisco	31.5
Washington, D.C.	66.3

PREPARED STATEMENT OF SENATOR CHARLES E. GRASSLEY

Mr. Chairman, I am very grateful that you decided to devote an entire hearing to the relationship between social problems and health care costs.

I've been interested in this relationship for some time. In fact, I requested that the Office of Technology Assessment incorporate a focus on social problems into its study of international health statistics. That study will be ready soon and I am looking forward to what it has to say on this subject.

I think your hearing will help to remind us that it is very important to keep clear the distinction between the health care system and the surrounding society.

In too much of our debate about the American health care system, we do not. This is nowhere more evident, or more annoying, than when we throw around generalizations that supposedly compare the quality of the American health care system with the quality of foreign health care systems.

In the first place, as I think this hearing will show, much of our high health care cost comes from social problems. Maybe we should even call them social pathologies.

These have absolutely nothing to do with the health care system. I'm talking about substance abuse, AIDS and other sexually transmitted diseases, violence, accidents, and adolescent/teen pregnancy.

In the second place, many of these generalizations about how much better health other societies get from what they spend on health care are not very helpful and are probably next to meaningless.

The reason is that they are usually based on health status indicators. And, as the OTA Report that I mentioned earlier will say, health status indicators are useful as social indicators, "but are not by themselves useful measures of the success or failure of a country's health care system."

Mr. Chairman, I think we need to ponder the implications of these points. Because we still have the "so what" question. I mean, once we acknowledge that social problems contribute to the high cost of health care, what do we do about it? And what does it mean for our health care reform debate?

I certainly don't have an answer to the "so what" question. The answer, if there is one, will emerge out of our health care reform debate.

As I said at the beginning of my statement, I very much appreciate the fact that you are making an effort with this hearing to focus on this dimension of the problem. If anyone can help us come to grips with this problem, Mr. Chairman, it is you, given the interest you have shown in these issues for more than 20 years.

But I do want to conclude with two or three responses to the "so what" question.

In the first place, maybe instead of doing so much worse than other countries, as all of this talk seems to imply or assert, our health care system is doing better than these other systems in some important respects, maybe a lot better. Maybe we are not doing as well as a society.

Maybe we are going to be very disappointed, after tearing our health care system apart and trying to put it back together—reformed—to find that we will still have high health care costs because that reform will have absolutely no influence on the kinds of behaviors I am talking about.

Maybe we need to be focusing on other policy areas in addition to health policy. Welfare policy, jobs policy, family policy, for instance. Then again, maybe there is nothing government can do to eliminate or reduce these social pathologies.

Maybe we need to think hard about how the health consequences of these social pathologies are going to be cared for in a reformed and community-rated health care system.

Some writers have already begun reminding us that the formation of health alliances is going to have some very big implications for who ends up paying the costs of these social pathologies.

I want to stop there, Mr. Chairman. I've already talked longer than I should have. But I hope that this Committee does not let this subject drop as we go forward with our discussion of health care reform.

They suggest also that alliance formation could have implications for, and for the effects on the access to health care for the people who have these kinds of health care problems as well as for As Elizabeth McCaughy pointed out in a recent, but already much talked about Wall Street Journal article, a lot of Americans are going to wake up post-reform and find that they are paying through their health alliances a great big fat increment in their insurance premium to take care of the health consequences of these social pathologies.

Yes, somebody is paying for those costs now. And, yes, we are all in this together, as I'm sure my Democratic colleagues will hurry to remind me. But I think that a lot of Americans are going to wonder why they will have to subsidize the health care costs of irresponsible behavior.

(including alcohol, tobacco, and illegal substances such as crack cocaine)
(including family violence and street violence)
(including auto accidents related to failure to use seatbelts or airbags)

How can you assess the relative ability of health care systems at providing high quality health care, or even at containing costs, unless you can account for the types of problems the surrounding society presents to those systems?

PREPARED STATEMENT OF TED R. MILLER

I am an internationally recognized safety economist. I direct the Children's Safety Network Economics and Insurance Resource Center and the Safety and Health Policy Program at the National Public Services Research Institute (NPSRI). NPSRI and its parent organization, the Pacific Institute for Research and Evaluation, are nonprofit organizations that specialize in research and development on substance abuse, injury, and violence issues. The Children's Safety Network is a group of six resource centers funded by the Maternal and Child Health Bureau in DHHS. The Network fosters development and inclusion of childhood injury and violence prevention strategies into organizations, programs, and services targeting maternal and child health or safety. Our Center, which includes the National SAFE KIDS Campaign, works to forge child safety partnerships with third party payers. It also informs the public and decisionmakers about safety economics.

My testimony today represents solely my own views and estimates. It is not the official position of my funders or my employer.

My testimony is divided into four sections. They describe:

- Injury's share of medical care spending
- The medical and societal costs of violence and related social problems
- The costs of injuries to employers
- The medical cost savings of selected injury prevention efforts.

All dollar estimates in my testimony are stated in November 1992 dollars.

Injury's Share of Medical Care Spending. Injury is widely known to be the leading cause of death at every age from 1 to 45 (Rice et al., 1989). It also is the largest contributor to health care costs from ages 5 to 50 and the second largest contributor among the very young and very old. (See Exhibit 1.) That conclusion comes from our ongoing analysis of recently released 1987 National Medical Expenditure Survey (NMES) data. Our analysis includes spending on hospital inpatient, outpatient, and emergency room care, physician and allied health professional services, prescriptions, emergency transport, and medical supplies and equipment, including eyeglasses. It excludes live birth, dental, nursing home, and insurance claims processing costs.

If the 1987 spending pattern is accurate, injuries caused $70 billion of the $522 billion in 1992 medical spending for services other than nursing home care. That was more than 13 percent. The injury costs included spending on late effects of back and joint injuries that happened years earlier.

Injury was second only to cardiovascular disease at $80 billion. It far exceeded cancer and genitourinary diseases (including kidney disease and sexually transmitted diseases) at $50 billion each. Two things may have changed the pattern of medical spending between 1987 and 1992—AIDS and improving medical technology which causes illnesses and injuries that once were quickly fatal to become costly and protracted but survivable episodes.

In 1992, medical spending on injury treatment averaged $288 per American (based on the 1987 distribution of costs). As Exhibit 2 shows, the highest per capita spending largely was among those aged 70 and over. On a percentage basis, injury spending is lower for the elderly only because other disease costs fall even more heavily on them.

Importantly, medical care costs are not the only public costs imposed by injury. Annually, almost 800,000 people are injured so severely that they permanently lose some capacity to work (Miller, Pindus, et al., 1994). That creates Social Security disability costs and home health services costs. It disrupts workplaces and drains society of productive labor.

Costs of Violence. Violence caused almost one fifth of injury medical care costs ($13.5 billion) in 1992. Suicides and hospitalized suicide attempts caused about $3 billion (Miller et al., 1994). Interpersonal violence cost $10.5 billion more (Miller, Cohen, and Rossman, 1993; Miller and Blincoe, 1994). Our interpersonal violence costs cover six crimes: murder, rape, robbery, assault, drunk driving, and arson. They are quite conservative. They exclude child abuse, other violence against children less than 12 years of age, and crimes, primarily rapes and domestic assaults,

that victims choose not to self-report in the National Crime Survey. In early 1994, through a grant from the National Institute of Justice, we will be able to provide costs of these excluded incidents.

I view drunk driving as a violent crime because it is an illegal act that maims and kills. This crime alone causes almost $7 billion dollars in medical care costs annually. That figure excludes the expected crash costs if the drivers had been sober. It represents crash costs attributable to alcohol (Levy and Miller, 1993).

Alarmingly, a drunk driver is behind the wheel for one in every 100 miles driven in this country. Every mile driven drunk costs the rest of society [people other than the drunk driver] $2.55. The costs include medical costs, property damage, emergency services, legal and administrative costs, employer costs, and wages and quality of life lost by innocent victims and their families. Twenty percent of auto insurance payments result from drunk driving. Again, these are just the costs attributable to alcohol.

We incorporated our drunk driving costs into existing estimates of alcohol costs (Rice et al., 1990; Manning et al, 1991). Alcohol abuse causes $18 billion in medical care costs annually. The effects of alcohol on crime, especially on child abuse and domestic assault, are underestimated. Every drink imposes a cost of $.63 on people other than the drinker. I consider that the optimal tax on alcohol. It equates to $1.38 per ounce, or $85 billion in annual revenue. Raising the alcohol tax is a proven way to reduce alcohol-related health care costs, especially among youth (Cook and Tauchen, 1982; Saffer and Grossman, 1987). Thus, taxing alcohol can reduce health care costs by deterring drinking while helping to finance health care.

Violence creates large mental health care costs as well as medical care costs. An exploratory survey of 168 mental health providers that Mark Cohen at Vanderbilt University and I just conducted shows that recent crimes caused $3.5 to 4 billion in mental health care costs in 1991. In addition, treatment of adults who were physically or sexually abused as children cost $4 to 6 billion.

For every murder in 1991, three people were in therapy. We estimate annual unmet adult mental health care needs due to interpersonal violence at perhaps $5.5 billion. Imagine the impact if we had adequate mental health care funding.

Guns are a large component of violence. They also cause unintentional injury, with young children commonly the victims. The number of gunshot victims is not readily traced. The firearm death toll was 36,866 in 1990 (National Safety Council, 1993). From case-fatality rates and hospital discharge data for Washington, California, and Vermont (three states where the cause of injury almost always is coded), I estimate another 75,000 to 110,000 were hospitalized. We have only a fuzzy estimate of non-hospitalized firearm victims, perhaps 200,000 to 275,000.

Using unit costs developed by Max and Rice (1993), I estimate the medical care costs of firearm death and injury in 1990 at $1.9 to $2.7 billion (in 1992 dollars). Wage losses were perhaps $20 to $25 billion more and quality of life losses three times that. By comparison, 1990 civilian firearm sales were about $2.1 billion (U.S. Statistical Abstract, Table 406, 1991, inflated to 1992 dollars). At wholesale, ammunition sales were about $491 million in 1992, including sales to police departments. Taxes on the ammunition sales were $54 million (McCarron, 1993). The medical costs alone were comparable to the sales revenues. Taxing arms and ammunition sufficiently to recoup their societal costs could raise considerable revenue. Recent research suggests that if taxation reduced gun sales, it also should help to check the violence (Loftin et al., 1991; Kellerman et al., 1992, 1993).

Costs to Employers. Employers bear most medical care costs of injury for the non-Medicare population. They pay the costs of injuries not only for benefit-eligible employees but for dependents. They also bear disability costs when benefit-eligible employees are injured on or off the job. The potential costs include sick leave, life insurance, Workers' Compensation and other short- and long-range disability insurance, and employer contributions to Social Security Disability/Survivors Insurance. Death and disability also tax the productivity of other workers. For example, they force supervisors to spend time juggling schedules and recruiting and training replacements.

Employers' injury-related fringe benefit losses and productivity losses by uninjured supervisors and co-workers dealing with the aftermath of an injury total $119 billion annually. That's $1,000 per employee. At a 10-percent profit margin, employers must make 1.2 trillion dollars in sales just to pay their annual injury bill. The bill includes health insurance, Workers' Compensation, life insurance, disability insurance, and sick leave payments.

Injuries cause 29 percent of health-related fringe benefit payments—$93 billion annually. They are 19 percent of employer health care bills ($35 of $184 billion). Injuries while working cause 11 percent of employer health care bills; injuries to

employees and dependents outside work cause 8 percent. Injuries also cause 48 percent of employers' disability bills. Injuries on the job alone produce 34 percent.

Medical Cost Savings of Injury Prevention. Injuries are largely preventable. Preventing them can save money while saving lives. Consider some examples.

Injury prevention should start at birth. Every dollar spent on child safety seats saves $2 in medical care costs (Miller, Demes, et al., 1993). Because seats are widely used, much of this savings already is realized by private health insurers. Seat use among Medicaid recipients, however, is only about 25 percent in most areas. If we gave every Medicaid mother a child seat as a baby present, Medicaid would save money. Eliminating seat misuse also offers major savings: $50 billion per year for health insurers and $73 billion for auto insurers.

Every dollar spent on bicycle helmets for children ages 4 to 15 saves about $2 in medical care costs (Children's Safety Network, 1993). The savings are $1.75 to $2.30 in health insurance payments plus $.80 to $.90 in auto insurance payments (largely associated with deaths and permanently disabling injuries).

Preliminary estimates that I am working on with the U.S. National Highway Traffic Safety Administration (NHTSA) suggest getting everyone into a safety belt would save $7.5 billion a year in medical care costs. Three recent case studies suggest employers implementing comprehensive belt use programs typically save $55,000 per million vehicle miles of on-the-job travel (Miller, 1993).

Attacking DWI also can be very cost effective. For example, the average dollar spent enforcing state laws against serving intoxicated patrons saves $10 in health care costs (Levy and Miller, 1993). From an employer's perspective, every mile that a benefit-eligible employee or dependent drives drunk costs at least $.30.

In violence, we have few proven interventions. One is home visitation for injury prevention. This activity has been shown to reduce child abuse, as well as unintentional injury (Olds et al., 1986). Other proven interventions are gun control and keeping houses and schools gun-free. Reducing media violence also is widely viewed as an effective countermeasure.

Conclusion. Violence and unintentional injury cause 13 percent of health care costs. These costs are often unnecessary; injuries can be prevented cost-effectively. Injury control can and should play a leading role in health care cost containment. That will require increased budgeting for prevention and for research to develop proven interventions.

Alcohol and firearms are major health care cost factors. Fully taxing their societal costs could raise more than $100 billion annually. Taxation can reduce health care costs by deterring drinking and violence while helping to finance health care.

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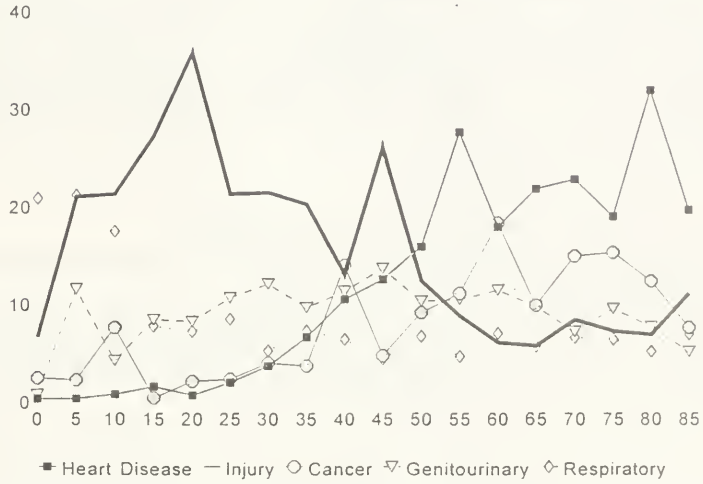
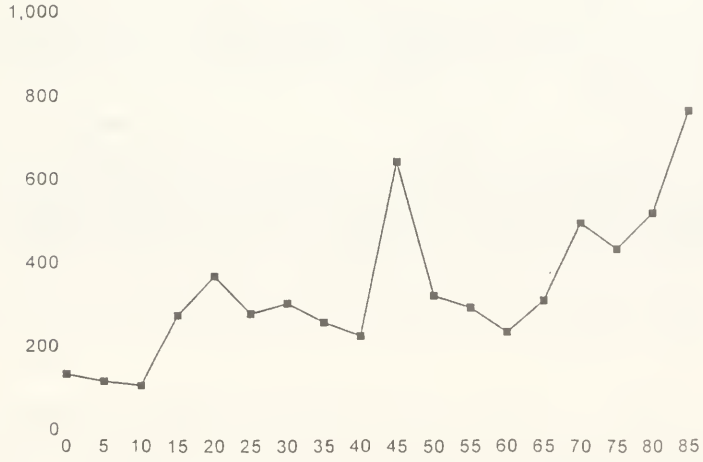
Exhibit 1. % of Health Spending by Age Group and Cause



Source: NMES Survey Data Compiled by National Public Services Research Institute, Landover, MD 1993
Excludes nursing home, dental, live birth, and claims processing costs.

Exhibit 2. Injury Cost/ Person by Age



Source NMES Survey Data Compiled by National Public Services Research Institute, Landover, MD 1993
Excludes nursing home, dental, live birth, and claims processing costs

PREPARED STATEMENT OF SENATOR DAVID PRYOR

Mr. Chairman, thank you for holding today's hearing on the important issue of how behavior affects our health care system. I would like to take this opportunity to commend your ongoing efforts and commitment to these issues—particularly your commitment to the issue of bullet-related violence.

Today we will hear from our distinguished panel of witnesses about substance abuse, violence, unsafe sex and other serious problems which daily eat away at our social fabric. These crises that challenge our families, our communities and our society present a challenge to our health system as well. And they pose serious threats to the safety and well-being of our young people.

Here are just a few alarming statistics:

- Every 35 seconds an infant is born into poverty
- Every two minutes an infant is born at a low birth rate
- Every 14 minutes, an infant dies in the first year of life
- Every day 135,000 students bring guns to school and every day 30 children are wounded and 10 children die from gun wounds.

You may think that these facts and figures apply only to places like New York City and not to a small, rural state like my home state of Arkansas. Unfortunately that is not the case. I recently heard that the homicide rate per capita in Little Rock has surpassed that of Detroit and Los Angeles. In fact, Little Rock has the highest homicide rate per capita of any city in the United States.

The extent of violence in Little Rock was highlighted by a recent survey conducted by the University of Arkansas for a group called "New Futures for Little Rock Youth." By the way, this group was started to address, among other issues, gang violence in Little Rock. The survey they conducted found that about half of those Little Rock residents surveyed have heard gunfire in the last year. And about the same number feel their personal safety is threatened by youth violence and gangs.

Violence is only one of the many public health challenges we face. Mother-to-baby drug exposure continues to increase in the United States. One study put the national price tag for treating drug-exposed infants at $3 billion annually.

Teenage pregnancy continues to be an alarming epidemic. Teen parents tend to be single and poor—factors that increase the likelihood of low birth weight infants requiring costly medical care. And, in 1991, Southern states alone spent $5.7 billion to support the families headed by teenagers.

Logic tells us the overall cost to our health care system is great; however, it is difficult to identify just where the unnecessary costs come from. It is estimated that at least one of every five Medicaid dollars spent on hospital care are attributable to substance abuse. The cost of a firearm-related fatality is estimated to be $375,520 per person. Clearly, we need to get a handle on these costs if we are to effectively address these issues.

These problems place an incredible burden on our health care system. However, a reformed health care system will not necessarily alleviate that burden. I am hopeful that within the context of health care reform we will not only identify and discuss, but also address these compelling public health issues. Mr. Chairman, I commend you for bringing these very important issues to the forefront of the health care reform debate. I look forward to the testimony of our distinguished witnesses.

PREPARED STATEMENT OF LEE RAINWATER

Births to Unmarried Women: Polices for Prevention and Protection

The steady rise in the share of births to unmarried mothers has continued now for more than a quarter of a century. It has been the subject of considerable comment and controversy, but has so far not met with a satisfactory public policy response. My colleague Reynolds Farley has summarized the demographic and social factors that lie behind this trend. I would like first to suggest some ways one might think about the social context in which the meaning of these trends can be found, and then discuss common policy options for dealing with the potentially precarious socio-economic situation in which families headed by a mother (whether never married, separated or divorced) find themselves in all countries.

In some ways, as is often the case with social problems, the raising ratio of births to unmarried women is a result of a signal success in private and public policy. The diffusion of effective family planning methods which received a major impetus in the 1960s has enabled many women to chose when to have children -- it has encouraged later age at marriage and for many married couples has lifted the burden of unplanned pregnancies and excess fertility. In thinking about my testimony today I was reminded that in the 1950s my first public policy research was concerned with understanding the family planning difficulties of poor and modest income married couples. Then the problem of controlling fertility was a big one for married couples; family planning clinics needed an understanding of marital relationships among the poor to do their job better. Since then the development of more effective contraceptives, changing sensitivity on the part of physicians to issues of family planning, and the growth of public funding of family planning clinics has had a dramatic impact on the ability of women and men to avoid marriages forced by pregnancy and to tailor their family size as they determine is best for them.

But, the result is that a higher and higher proportion of births are to unmarried women. Our policy success at family planning for married couples, since it has not been matched by similar success in family planning for unmarried women and men, has resulted in a rising ratio of births to unmarried women.

Given this policy failure we are confronted with two kinds of challenges for future social policy -- policies for prevention and policies for protection.

Policies For Prevention.

That family planning policies for unmarried women have not been successful may well be a textbook illustration of a standard sociological paradigm for understanding social problems. Social problems arise as a result value conflicts in society -- we want contradictory things. On the one hand we want unmarried women not to have children whom they can ill afford to care for. On the other hand we want to uphold traditional notions of sexual morality so we are reluctant to promote family planning services to unmarried girls and women, particularly the former. It's not just that liberals think one way and conservatives another, but many people -- including those who establish and implement policy -- are immobilized by these value conflicts.

It is understandable that wishfulness takes center stage when resolution proves difficult. Over the decades up to the sixties many social observers announced that a revolution in sexual mores was in progress. When social scientists looked they found little evidence that this was so. But, in the 1960s that revolution did indeed take place. Since then the operating, as opposed to official, morality of the country has been one that expects sexual activity among unmarried teenagers and adults. But because we find it so difficult to cope with our value conflict about issues arising from this sexual revolution it is a constant temptation to look for ways to undo the change through public policy. But these deep cultural and social shifts are not controlled by policy. Policy can only adapt to them or ignore them and tolerate the consequecies of so doing.

As more surveys of sexual behavior are done in other countries (as a response to the AIDS epidemic) we are learning that the level of nonmarital sexual activity is about the same in most European countries. But, in those countries the value conflict is not so intense. As a result it appears that although European unmarried teenagers and adults are as sexually active as in this country, unplanned births are rare. There are probably many reasons for this but one certainly has to do with the availability of, and promotion of, family planning in connection with the regular operation of the health services, and in some countries of the educational services.

One positive effect of the proposed national health program should be the facilitation of family planning services for all women and men, but most particularly for the unmarried and the young -- as happened dramatically in Mexico in the 1970s. When the government reversed it anti-family-planning policy it had a nationwide health service through which to channel the implement the new policy and birth rates quickly declined.

Clearly a serious effort at providing family planning services for unmarried women and men could reduce the ratio of births to unmarried women. The rates among the poor, particularly those in areas of concentrated poverty areas might still be high compared to those for other social groups. Poverty itself, because it persuades people that they have little hope of bettering themselves undercuts the motivation to control one's situation. But, by the same token, programs that impress on poor people that the rest of society is doing things to help them pull themselves up can have a positive effect on the efforts the poor make for themselves and their families.

Policies for Protection.

The statistics that we have reviewed show that thirty percent of our new fellow Americans are born to unmarried mothers. Even with new policies of prevention that proportion is like to rise toward forty percent by the end of the century. We have little reason to believe that more than a few of those children will in fact have more than intermittent social and financial support from their fathers. Their mothers are very likely to be poor, particularly in their early childhood. In this respect they share their fate with children of separated and divorced parents. Yet these people will be workers in a generation's time. American society will have to rely on them to produce, to finance government, to pay the retirement income of their elders. The social cost to the children, their families and the rest of American is likely to be great if policies for protection are not put in place.

One way of exploring the relation of policy to disadvantage in solo mother families is to compare the experience of the United States with that of other rich countries.

The United States has a higher proportion of single parent families that other advanced industrial countries. I draw here on data from the Luxembourg Income Study, which assembles social and economic survey data (like the U. S. Current Population Survey) from some twenty nations. We find that while in the mid 1980s the United States had the highest rate of persons in families with children living in solo mother families (19%), several other countries had significant numbers of persons in such families -- for example Sweden and the United Kingdom at 14%-15%, and Australia and Canada at 11%.

But, there were great differences in the poverty rates of solo mother families. Three countries had very high rates -- the United States (58%), Australia (61%) and Canada (51%). In sharp contrast countries such as France, the Netherlands, Sweden and the United Kingdom all had rates under 20%. Why?

In two of these countries, France and Sweden, a higher proportion of solo mothers have earnings than in the United States. But in two others -- the United Kingdom and the Netherlands -- the proportion is much lower. Variations in how many solo mothers work, and how much they earn, plays a role in reducing poverty, but it plays a bigger role in some countries than in others.

And it is the same with transfers. Other countries have a many different kinds of transfers to solo families, and most of these transfers go to families with earners as well as nonearners. The transfers include child allowances, enforced child maintenance payments, housing allowances as well as traditional social security programs such as unemployment insurance and survivors and disability pensions. Together they loom large in the income package of many of these countries. The transfers to solo mother families average from fifty percent to two-thirds of the poverty line in countries like the Netherlands, Sweden and the United Kingdom, and forty percent in France and Australia.

In general, if solo mothers do not have earnings they are poor -- only countries like Sweden and the Netherlands have low poverty rates for those completely dependent on transfers. But it is the combination of earnings and transfers which explains the different rates of solo mother poverty across countries.

If we focus on the great majority of solo mothers who have earnings we find that the United States has the highest poverty rate (42%) because solo mothers have lower earnings than in other countries and they receive lower transfers. Working solo mothers in Canada are somewhat better off (33% poor) but there, too, both earnings and transfers are low. In Australia working solo mothers have similarly low earners but do better on transfers; as a result only 25% are poor. The level of transfers is about the same in France, but earnings are much higher so the poverty rate drops to 11%. Sweden has a very low poverty rate for working solo mothers (and remember that 95% of them work) because they have high average earnings and high transfers.

To summarize these rather complex patterns of earnings and transfers across countries we can say that policies for the protection of solo mothers and their children have been developed that are effective in some countries but they require a combination of work and social transfers. The transfer programs differ from country to country, even the mix of income-tested and universal transfers differs, but transfers as a supplement for work (not a substitute for it) are an essential part of keeping solo mother families out of poverty.

But, transfer policies have to work hand-in-hand with policies that facilitate solo mothers' desires to work, and to earn a living wage. Child care policies do this two ways -- they give mothers time for work, and they employ some of them. Transfer programs such as the Earned Income Tax Credit which do not penalize work can have a large impact of solo mother poverty.

RESPONSE OF DR. RAINWATER TO A QUESTION SUBMITTED BY SENATOR GRASSLEY

You noted that the effective protections for solo mothers and their children seem to require a combination of work and social transfers. In the countries you have studied, is the work option required as a condition of receiving public transfers, or do the societies seem to provide work opportunities without public policy initiatives?

Work is seldom required as a condition for receiving transfers in the countries I have studied. Some transfers are universal in that they go to all families which qualify; eg. have a child, or perhaps three children. Assured child support is available to all single parents without a work requirement.

Other transfers (e.g., housing allowances) are income tested (seldom actually means tested) but do not require work availability as a condition. Unemployment payments do require the recipient be available for work.

Some countries, particularly in Scandanavia, substitute active labor market programs -- public works, job retraining -- for unemployment insurance for many of the unemployed.

PREPARED STATEMENT OF LEROY L. SCHWARTZ

Americans should not be too quick to radically alter their health care system. Critics attack the system for its excessive cost and its failure to provide a sizable segment of the American population with access to quality care, but the system is getting more than its fair share of the blame for these problems. There is a major reason underlying the cost of American health care: A significant number of Americans exhibit excessive rates of illness and death. The uniqueness and complexity of American society and its special requirements demand a health care system that must be tailored to our needs. Proposals brought forward thus far, including single-payer, managed competition and pay or play have not addressed those needs.

President Clinton, in his address to the City Club of Cleveland on May 10th, indicated his awareness of the problem. He said ". . . we must face the biggest exploder of the deficit, and perhaps the biggest human dilemma America faces—and that's the health care crisis. . . . this year we're going to spend 15 percent of our income on health care. The next nearest country will not spend 10 percent. Now, we should be spending more for a number of reasons: Number one, we do more on medical research than any other country. Number two, we rely more on new technologies, and we enjoy that when we need it, as opposed to somebody else needing it. Number three we have a more diverse population with more poor people than most other advanced countries, more cases of AIDS than most other countries, and we are a more violent country than any other advanced country. So we pay more money, keeping emergency rooms open on the weekend for people getting shot and cut up. . . . we cannot get our costs down to the level of other nations unless we make changes dealing with these big structural things."

THE AMERICAN DILEMMA

The United States has a society that includes approximately 50 million people living in poverty. While most of these people are white, many of the poor are minorities—especially African-Americans, Hispanic Americans, and Native Americans. In addition, a large number of Americans exhibit certain behavioral risk factors contributing to severe health problems. Although many of these people receive care, it is frequently late in the illness, in the emergency room, and, therefore, much more expensive. Social pathologies such as the breakdown of family structure, chronic unemployment, poverty, homelessness, substance abuse, violence, and despair wind up in the emergency rooms, intensive care units, and morgues of our hospitals. America's many social problems—poor housing and overcrowding with a resulting high rate of tuberculosis (TB); drug abuse leading to its own pathology, in addition to violence and sexually transmitted diseases (STDs); high-risk pregnancies leading to premature births, infant morbidity and mortality; and alcoholism leading to cirrhosis and other illnesses—contribute not only to the higher cost of care in this country but also to certain relatively poor gross measures of health, such as our infant mortality and life expectancy rates. As mentioned above, this additional pathology is a result of poverty compounded by certain destructive behaviors found in this country. In other words, our severe social problems are paid for once they become medical problems.

The incidence of premature infants with low and very low birth-weight—frequently related to socioeconomic conditions and certain behavioral risk factors—is considerably higher in the United States than in other developed countries. Our health care system has been particularly responsive to this problem. The recent decline in our infant mortality can be attributed largely to improved survival rates of these babies and other small infants whose lives are saved primarily because of more neonatal intensive care programs. However, this use of high technology is extremely expensive. It costs an estimated $2.6 billion annually—and this figure does not include the long-term, frequently lifelong costs of caring for those with residual disabilities.

EXPENSIVE PROBLEMS

There are many other illustrations of expensive health problems related to behavioral factors occurring more frequently in the United States than in other developed countries, especially among the poor and minority groups:

- Unintentional injuries are widespread in this country compared with other developed countries and are a leading cause of death among our children and young persons, particularly those in minority groups. A recent Rand Corporation report indicated that the medical and other direct costs of injuries represented about $90 billion of the $176 billion that accidents cost annually.

- Physicians and nurses, particularly in emergency rooms, constantly treat an array of victims of violence. There are more than 20,000 homicides in the U.S. annually. The male homicide rate in the U.S. is ten times the male homicide rate of Britain and Germany and four times that of Canada. An indication of the immensity of the health care problem—as depicted in one study—is that for every homicide, 50 victims of crime receive care in the emergency room or hospital. Spinal cord injuries illustrate the financial implications: More than 25 percent of these injuries—about 45,000 people—result from violent assaults. The lifetime cost of quadriplegic treatment, for example, can be as high as $600,000 per person.
- Drug abuse and unsafe sex are associated with the estimated 1 million persons infected with the HIV virus. According to a CDC report of December 1992, there were over 200,000 cases in the U.S. of severe immunosuppression or AIDS-defining conditions—four times the Canadian rate—costing some $119,000 per person for lifetime treatment. The estimated annual cost for AIDS is expected to be over $15 billion by 1995.
- There are up to 375,000 drug-exposed babies born each year in this country. The treatment of these infants is $63,000 per baby for the first five yearn of life alone, or about $23.6 billion.
- Pelvic inflammatory disease (PID), an infection of the female upper reproductive tract, affects from 10 to 15 percent of women of reproductive age in the U.S., according to a recent National Institutes of Health report. Up to 1 million new cases are added annually. Most cases of PID are caused by sexually transmitted organisms and are related to such preventable sexual practices as first intercourse at a young age, a high frequency of sexual intercourse, and multiple sex partners. Treating PID cost this country about $3.5 billion in 1990 and that is expected to rise to $8 billion annually during the next ten year.
- There are 18 to 22 million individuals with alcohol or drug problems that benefit from treatment. A comprehensive substance abuse treatment program is conservatively estimated to cost $19 billion per year or $12.4 billion above the $6.7 billion being spent by the system in 1993. At least one of every five dollars Medicaid spends on hospital care are attributable to substance abuse. The estimate for FY '94 is $7.4 billion. Estimates vary about the total direct and indirect cost of substance abuse to the health care system: They run as high as $140 billion a year.
- In addition, TB, an infectious disease previously thought to be under control, is reappearing in a new drug-resistant strain and increasing at a rapid rate in our poor population, especially among substance abusers and persons with AIDS. From 1989 to 1990 the number of TB cases increased 9.4 percent—the largest rate of increase since 1953. More than 25,000 new cases were reported in 1990. In certain states the rate of increase is much higher. For example, in New Jersey, the TB caseload increased by 36 percent during the last five years.

EFFECT ON HEALTH CARE COSTS

If Canada, Germany, or Sweden had our social problems, a comparable poor population and behavioral risks, their sickness and death rates surely would be much worse and their health care costs would be much higher. Those who propose a radical reform of our health care system as the answer to the rise in health care costs and the problems of access may find that unless we are able to reduce the amount of care required in this country, the result may be large-scale rationing. Thus, the commonly cited differences between the U.S. and foreign health care costs may have less to do with our different health care systems than with our widely divergent populations. Nevertheless, evidence is emerging that despite the flood of illness resulting from our poverty and behavioral risks factors, our health care system is performing better than is generally understood. A closer examination of our infant mortality rate indicates that this country saves relatively more babies with low birthweight and babies from age one month to one year—probably through application of intensive medical care and high-cost technology—than do other highly industrialized countries. Sweden, for example, has made the societal decision to withhold treatment, with the effect that some infants die who otherwise might have survived.

In addition, there is evidence that for many conditions amenable to medical or surgical interventions such as cancer, heart attacks, and enlarged prostate, U.S. death rates are frequently lower than those of the countries with which we are generally compared, particularly for populations over the age of 50. (Infant mortality and life expectancy, which generally are used as the measures of the quality of a health care system, are much more dependent upon social factors.) Other countries' higher death rates may be related to the long waiting lists found in a number of

health systems administered by governments, which could postpone or deny people lifesaving medical and surgical care. This particularly would be a problem in the U.S., where our poverty and behavioral risk factors tend to compound the well-known tendency of poor and minority patients to put off seeking preventative and curative care. While the evidence is tentative, it does suggest that although Americans are paying more for health care, we may indeed be getting more. Given the nature of the issue, extensive new research is needed.

Finally, recent surveys indicate that Americans overwhelmingly consider the health care they receive to be of good quality, but they are dissatisfied with its sharply rising cost and the inadequate protection afforded by our health insurance schemes. For example, a 1993 survey by Robert J. Blendon of the Harvard School of Public Health and John Marttila found that 89% of Americans are satisfied with the care they receive from their own doctors. At the same time, 47% are worried that they or someone in their household could fall into the uninsured category in the next five years. Thus, any changes in our health care system should carefully retain its quality aspects, offer adequate financial protection, maintain public satisfaction, provide a high level of care, and preserve the excellence of our medical research. This can be achieved if the U.S. makes the commitment to resolve our social problems before they become medical problems—at the same time, innovatively addressing our present, vast, health care needs. Only then can we avoid rationing health care to the poor, the elderly, and the middle class—a characteristic of many health care models some people suggest we adopt.

The real challenge to our policy-makers is not to ration care to save money, as other countries often do, but to extend American health care, research, and technology—frequently the best in the world—to the remainder of our population, including the poor, at an acceptable cost. For while there is little doubt that the U.S. health care system needs improvement and can be improved without destroying its excellence, it is likely that our pluralistic approach is best suited to a pluralistic America.

RESPONSES OF DR. SCHWARTZ TO QUESTIONS SUBMITTED BY SENATOR GRASSLEY

Question No. 1. I suppose you could argue that the rate of increase of health care costs can't be explained by social pathology, as contrasted with the level of costs. But let me ask this. Has there been an increasing level of social pathology that tracks with the rate of increase in health care spending? I think of the recent cultural indicators index advanced by Bill Bennett, which was an attempt to quantify changes in behavior and attitudes. His indicators showed what I think most of us would agree is a decline in cultural indicators.

For instance, he found a 560 percent increase in violent crime over the last thirty years and a 419 percent increase in births to unwed mothers.

Answer. The exact relationship between social factors and health care costs is a complex one. Bennett's cultural indicators and other research substantiate the increase in violent crime as well as the increase in births to unwed mothers. During the same period (the last thirty years), there has also been an enormous increase in health care costs. We believe that there is more than just an correlation between the level of social problems and the level of health care costs but the exact extent to which there is a cause and effect relationship between the two requires further study. Illnesses and conditions caused by social problems and high-risk behaviors such as violence, drug abuse and unsafe sex certainly contribute substantially to higher health care costs.

Question No. 2. I don't know if you saw the op ed piece by Leonard Laster in the Washington Post on Wednesday last week (October 13, 1993). He makes this statement in his article:

> ". . . . when we cap total national health care expenditures, almost all of the cost reduction pressures will be transmitted to the health care we give for the problems not derived from social pathology. That care will suffer disproportionate budget reductions, and eventually it will be compromised."

I would like to hear your thoughts on this prediction.

Answer. The prediction made by Laster (Washington Post, 10/13/93) is an interesting speculation about the possible effect of a global spending cap on diminishing the care available for health problems not associated with social pathology. Since we believe a considerable amount of medical care is caused by social problems, any cost reduction will affect health care expenditures for those problems and for other care not necessitated by social problems. Also, the accuracy of this prediction depends on the way spending caps are set and transferred to the states and regional health alli-

ances as well as the extent to which subsidies are made available to alliances which cover geographic areas with a high volume of social pathology.

Question No. 3. A second, related, question has been raised in an article in the Wall Street Journal on September 30, 1993 by Elizabeth McCaughey that has created something of a stir. Her article criticized several elements of the President's health care reform plan as it was laid out in that document which started circulating three weeks ago or so.

She argues that some participants in urban alliances are going to get stuck with unfairly high health insurance premiums. As I understand her article, the combination of community rating and the burden of social pathology found in urban areas is going to cause premiums in these alliances to be very high.

So, to draw the moral of the story, the individuals who take good care of their health, do not smoke, do not drink, exercise, do not engage in risky behaviors, and hence have few health care problems, are going to be paying high premiums to subsidize the health care of people who have higher health care costs because of their irresponsible behavior.

Can you comment?

Answer. The nature of insurance involves spreading risk over a large number of people with the effect being that healthier people pay for those sicker than themselves. When the sickness is self-induced, as is frequently the case in our urban areas with a large volume of social pathology and the number of people left to pay for that is relatively small, each person may be asked to pay a much larger amount of money even though their own need for care is very small.

McCaughey is probably correct in her view except to the extent that the premiums of one alliance may be subsidized by federal or state governments or by raising premiums in the other alliances outside the urban areas.

The American Health Care Dilemma: Social Factors

Chart 2

Expenditures for Social Security and Health Care, by Country, 1983

Country	Share of GNP spent on social security	Social security health component as share of GNP	Share of GNP spent on total health care	Share of GNP spent on social security plus total health care
Canada	16.6	4.8	8.7	20.5
United States	13.6	3.0	10.8	21.4
Netherlands	33.3	6.0	9.3	36.5
United Kingdom	19.9	4.7	5.9	21.1
Federal Republic of Germany	27.4	5.9	9.5	31.0
France	30.4	6.4	9.2	33.2
Sweden	34.1	8.4	9.8	35.5
Japan	12.0	4.7	6.7	14.0

Source: Joseph G. Simanis
Social Security Bulletin, January 1990/Vol. 53, No. 1

Chart 3

Healthcare System Pays For More Than Healthcare

I. Medicalization of Social Problems ($121.5 billion)
- A. Smoking ($22 billion)
- B. Drug abuse and rehabilitation ($10.6 billion)
- C. Alcohol abuse ($58.2 billion)
- D. Unsafe sex
  1. AIDS/HIV ($15.2 billion)
  2. Pelvic Inflammatory Disease ($4.2 billion)
- E. Violence ($5.3 billion)
  1. Homicides
  2. Assaults
  3. Rape
- F. Gambling ($6 billion)
- G. Tuberculosis

II. Poverty and Medical Indigency ($25-50 billion)

Sicker population, legal/illegal immigrants
- a. Later attention to problems
- b. Lack of immunizations
- c. Lack of preventative care
- d. Increased care and cost

III. Cultural Attitudes of Society ($53.7 billion)
- A. Saving all high-risk babies ($3 billion)
- B. Elderly treatment at end of life ($30 billion)
- C. Malpractice ($20.7 billion)

IV. Fraud and Abuse ($93.0 billion)

Medicalization of Social Problems	$121.5 billion
Poverty and Medical Indigency	$25-$50 billion
Cultural Attitudes of Society	$53.7 billion
Fraud and Abuse	$93.0 billion
SOCIAL COSTS: TOTAL	$293.2-$318.2 billion

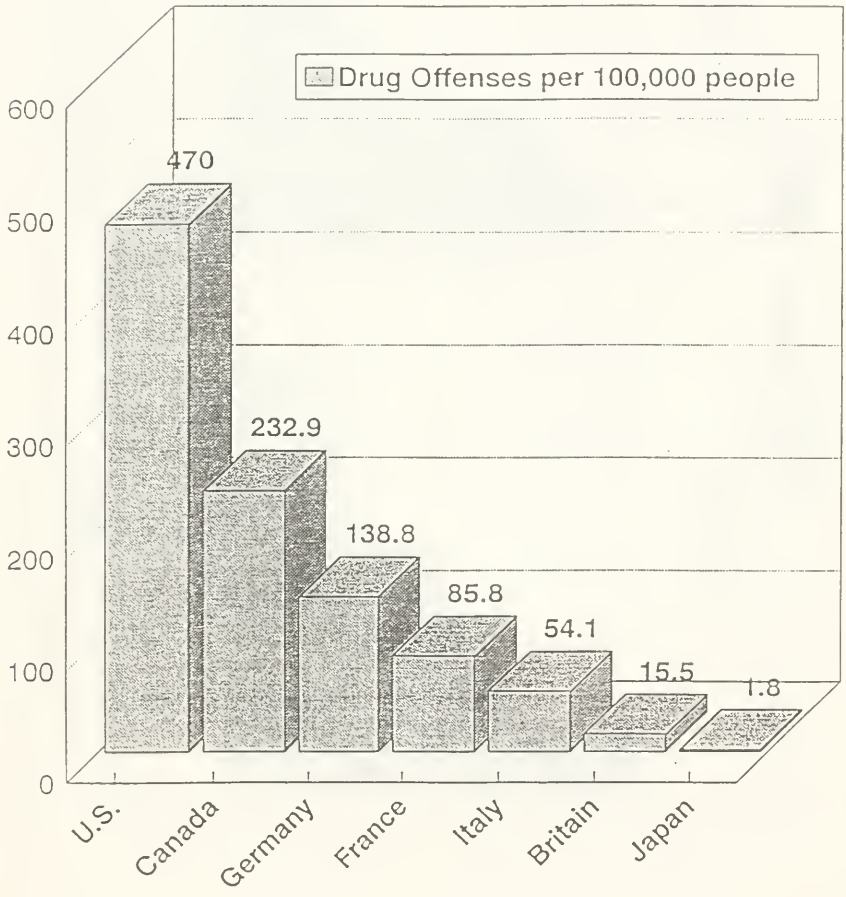
Total "Healthcare" Spending: $930 billion

SOCIAL COSTS: $300 billion	HEALTH COSTS: $630 BILLION

Chart 4

Drug Offenses: *1988*

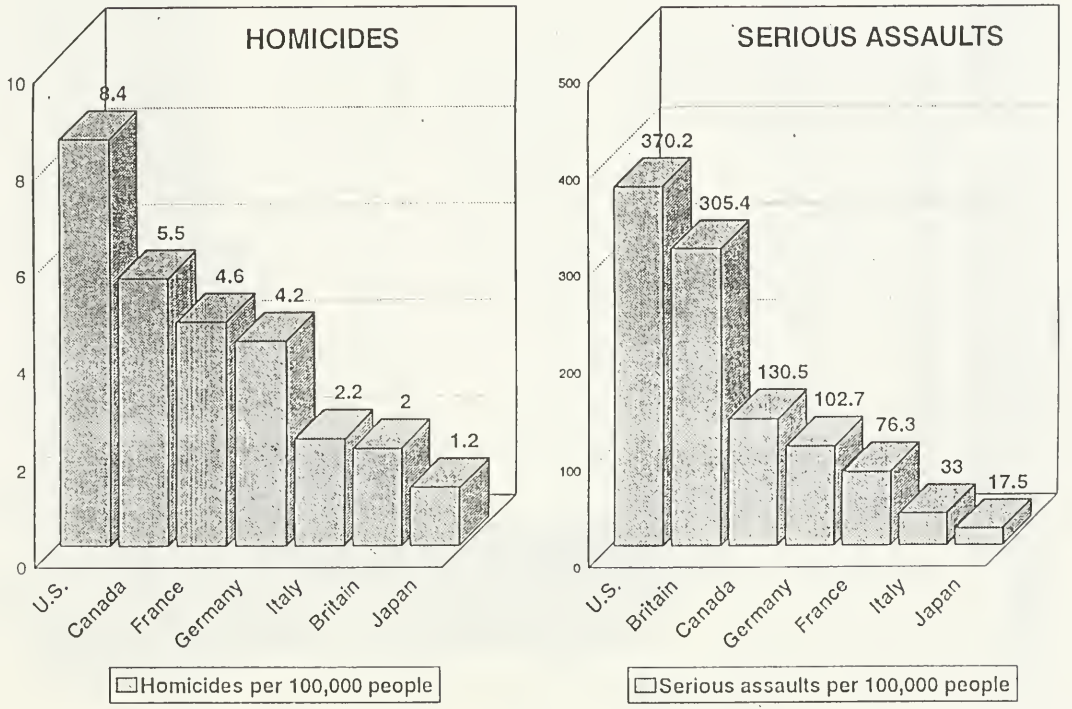
International Comparison



SOURCE: World Health Organization

Chart 5

Violence: *1988*



SOURCE: Interpol

Simulating the Cost of Substance Abuse Treatment Under Various Health Care Financing Reforms

Specialized Substance Abuse Treatment
System Costs and Services Delivered
(1993, and Under Selected Reform Models)

		Reformed Treatment System Orientation			
	System in 1993	Comprehensive/ enhanced	Mixed	Public	Private
Cost per year ($ in billions) 	$6.70	$19.10	$9.00	$10.60	$8.60

A comprehensive substance abuse treatment expansion and improvement benefit like that advocated by the Legal Action Center (LAC) is conservatively estimated to cost $19 billion per year ($72.50 per person in the U.S.). This is $12.4 billion above the $6.7 billion that will be spent to treat 3 million persons in 1993 ($25.50 per person).

There are 21 to 22 million individuals with alcohol or drug problems that benefit from treatment. It is assumed that health care reform would increase access to substance treatment (the number of substance abusers getting any treatment) by about 50 percent.

Source: Lewin - VHI

Chart 7

Costs The Public Will Understand
-Drug Rehabilitation-

On the average, each U.S. worker pays $5,000* in federal income tax

Social Cost to Medical System

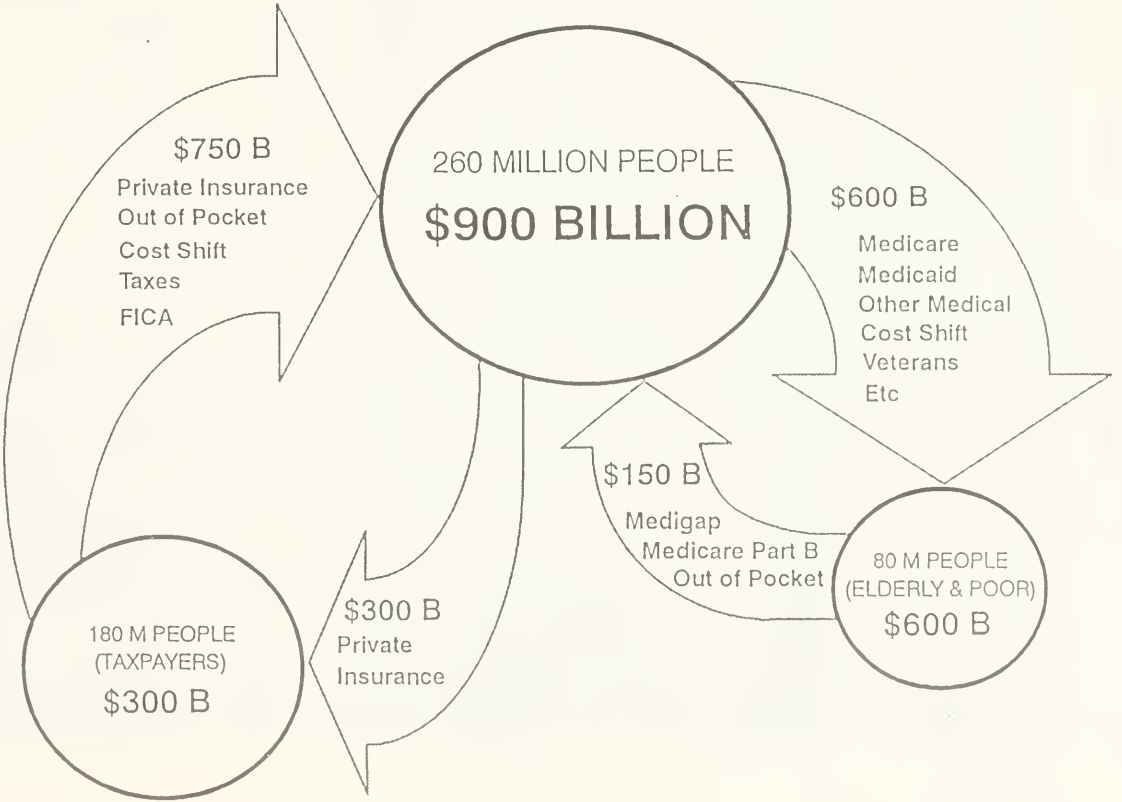
Estimated Cost	At	Number of Taxpayers
19 billion**	$\frac{\$19 \text{ billion}}{5{,}000}$	3.8 million

* IRS Data

** Recommendation of Law Institute

Chart 8

Who Pays For Healthcare?



Prepared Statement of Louis W. Sullivan

INTRODUCTION

Thank you, Mr. Chairman. I welcome this opportunity to testify before the Committee.

THESIS

Our common mutuality is nowhere more evident than in health care, where our individual actions can affect many others throughout our lives.

SOCIAL CONSEQUENCES

Mr. Chairman, we must assist our citizens to better visualize the impact of particular unhealthy actions. For example, the decision to smoke is responsible for one of every six deaths in America, 435,000 deaths per year, more than 1,200 every day. Smoking costs the United States over $65 billion annually in health care costs—a hidden tax of more than $221 dollars on each and every person in our country. A recent study by the Columbia University Center on Addiction and Drug Abuse has found that $2 Billion of Medicaid hospital expenditures in 1991 was a result of tobacco use.

The decision to abuse alcohol or use other drugs is also costly. Violence, crime, unemployment, and other social problems have been linked to illicit drug use. There are also economic costs: the annual costs for alcohol and drug abuse are between $100 and $200 billion.

Mr. Chairman, each year there are more than 500,000 Americans who die from coronary heart disease, and the annual economic cost of this disease is well over $100 billion. By emphasizing better health practices through health education and public information campaigns, there was an almost 30 percent reduction in age-adjusted death rates due to heart attacks in the United States from 1978 to 1988. Through healthier lifestyles, the appropriate use of medications, and other actions, a further 60 to 80 percent reduction may be possible, with great costs savings for the nation.

And we know from a growing volume of studies that family disintegration, dropping out of high school, teen pregnancy, poverty, poor health status, disability, and premature death are all inter-related—even inter-generational—as you have so elegantly documented in your own writing, Mr. Chairman.

As a power-walker, I am also aware of studies that show exercise—especially brisk walking—has positive returns in later life. Over a lifetime, each extra mile that a person walks gives him or her approximately 21 extra minutes of life and saves society 24 cents in external costs. Conversely, our society pays around $1,650 in lifetime medical and other costs for each person who does not exercise.

PREVENTION AND REFORM

These are but a few of the examples that document a link between behavior and health. But, Mr. Chairman, there are many people who remain unconvinced of the value of health promotion/disease prevention efforts. We will never have meaningful, coherent, constructive, effective health care reform without strong, vigorous, and credible prevention efforts on a wide range of fronts. Reform is not merely about passing laws in Washington or in the states. Reform is not simply adjusting the financing or the delivery of medical care. Comprehensive national reform must include each and every American, our families, our corporations, and all of our institutions—public and private. Our citizens must be persuaded to make a personal and cultural transformation to achieve better health status.

We have a unique, singular, unprecedented moment in history to explain these relationships and to empower our citizens to become part of the health care solution through the individual decisions they make. Translated into strategies that would mean healthier, longer lives for our citizens, we must work to help people stop smoking; end alcohol abuse; eliminate drug use; avoid the high risk behavior that spreads the AIDS virus; seek early prenatal care during pregnancy; improve eating habits; wear seat belts; increase exercise; resolve conflicts without violence; and seek necessary medical examinations and vaccinations. By improving our health behavior, we could eliminate 45 percent of deaths from cardiovascular disease, 23 percent of deaths from cancer, and more than 50 percent of the disabling complications of diabetes. Control of fewer than ten risk factors could prevent between 40 and 70 percent of all premature deaths, a third of all cases of acute disability, and two-thirds of all cases of chronic disability.

HEALTH DISPARITIES

Mr. Chairman, we must also make greater efforts to reach out to our poor and minority communities. There are more than 73,000 excess deaths per year in our nation's minority communities. And, while the health of the population in general has improved each year, black health status has not improved over the last decade. Recent studies in the *New England Journal of Medicine* reported that the gap in health status between rich and poor has actually widened over the last twenty-five years, an inequality fueled by a *growing* disparity in mortality between Black Americans and White Americans. These studies documented that our poorest citizens are least likely to have good health status.

We must make our health care system more culturally sensitive and user-friendly for our poor and minority communities, and that includes more credible and comprehensive prevention programs. Prevention programs are *virtually non-existent* in many urban and rural areas, and, when available, many prevention programs have little credibility, or are viewed with suspicion or misunderstanding. We must offer a straightforward, believable message that motivates behavior change, without alienating our citizens.

PUBLIC SECTOR ACTIONS

Mr. Chairman, there is much that the government can do to help our citizens to empower themselves. You may recall that in my confirmation hearings before this committee four-and-a-half years ago, I pledged to make prevention a high priority, to make it a legacy of my tenure as Secretary of Health and Human Services. So I was pleased that during my time in office we released *Healthy People 2000,* a blueprint of our nation's health objectives during this decade, and a powerful plan for greater health promotion/disease prevention efforts. We also reorganized HHS, creating the Administration for Children and Families to make our programs more effective in strengthening our families. Our initiatives in food labeling were designed to empower our citizens make better-informed choices about their diet. We also used the bully pulpit of public office to inform our citizens, such as in my anti-smoking campaign, launched in January, 1990. We also stated that violence is a public health problem, and we must address the causes of violence while the criminal justice system confronts its effects. I was very supportive of a strong, energetic Office of Minority Health at HHS—an office that is an essential ingredient in any credible prevention campaign for our minority communities.

We must build on this legacy. The public sector must explore other efforts to help our citizens protect their health through their daily decisions.

PRIVATE SECTOR ACTIONS

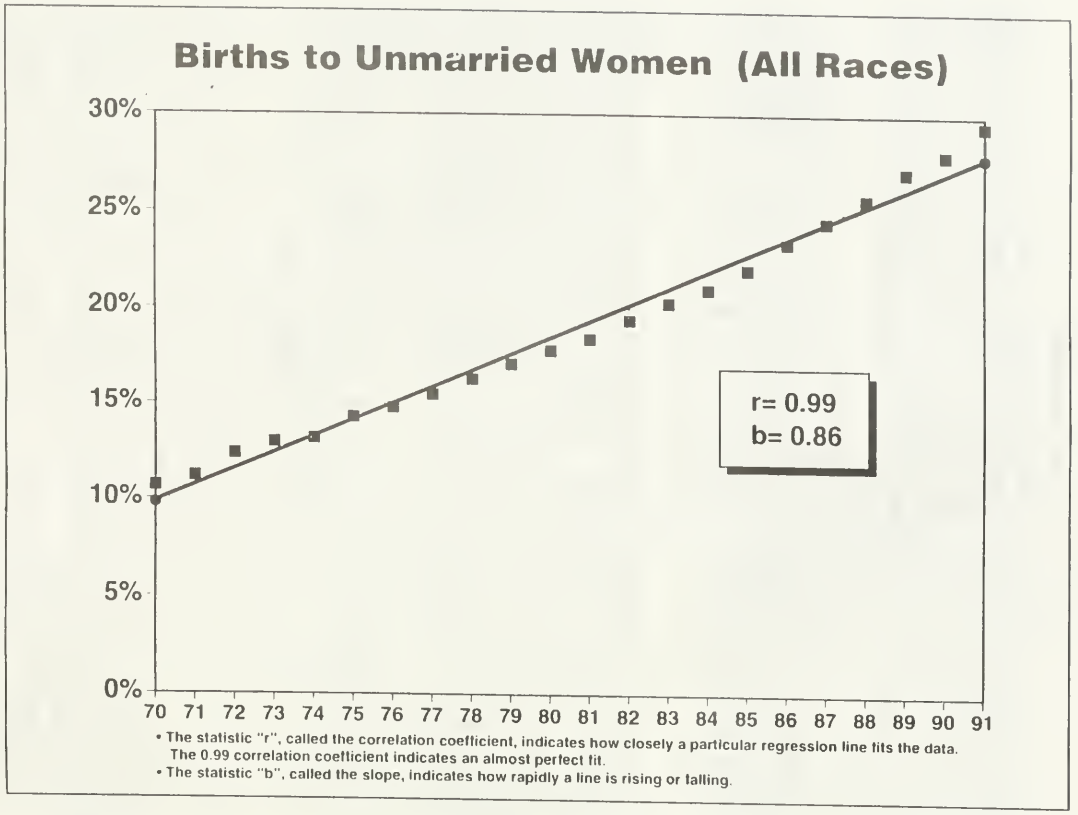
The private sector should also get involved. For example, we need more of our physicians to be primary care practitioners. Primary care physicians help to educate and inform our citizens about avenues to better health. I am proud of the fact that the Association of American Medical Colleges found that the Morehouse School of Medicine is the number one medical school in the nation in the percentage of graduates practicing as primary care physicians. In addition, the Morehouse School of Medicine has, among its community outreach programs, a Health Promotion/Disease Prevention Resource Center.

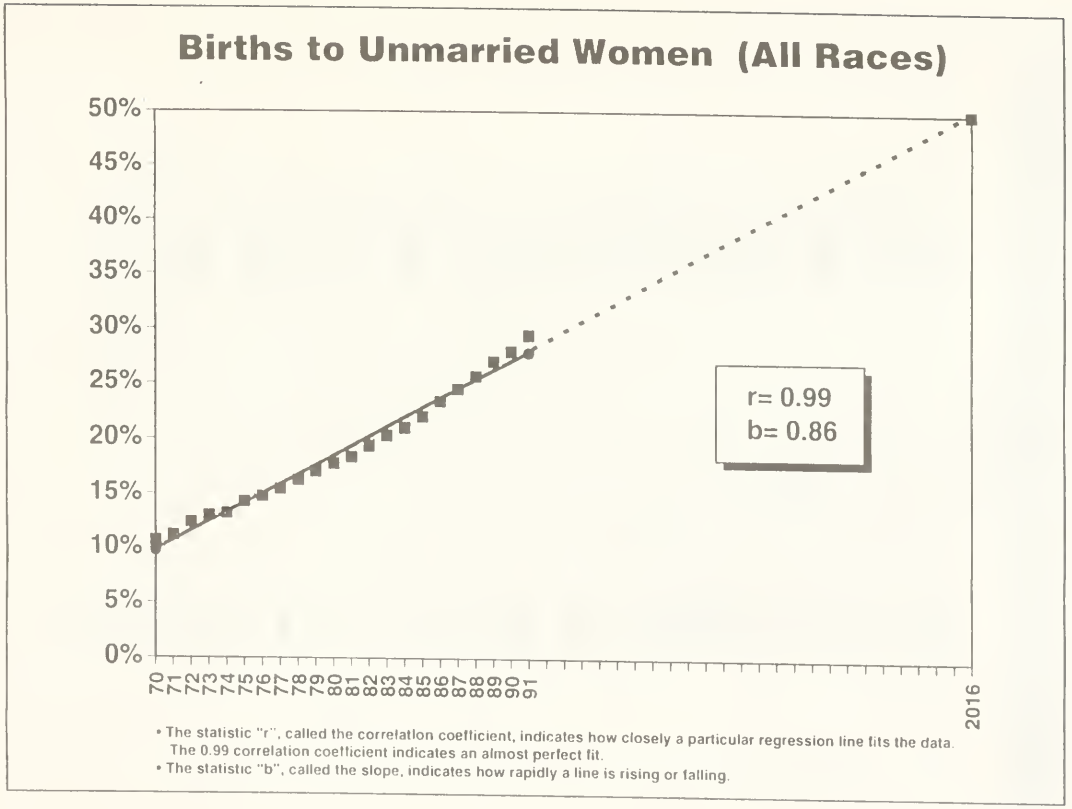
Philanthropic organizations can also provide people-oriented training and prevention programs, such as efforts by the Kellogg Foundation for primary care community partnerships, and the Robert Wood Johnson Foundation's Primary Care Training Initiative. We need to expand such programs to effectively address the national need for more primary care physicians, and the need for improved health behavior by our citizens.

CONCLUSION

Mr. Chairman, we must do nothing less than create a culture of character—a greater sense of personal responsibility and community service. To succeed in this, we must enlist the leadership and support of our churches, our schools, our community leaders and associations, and other value-generating institutions in our society. As we reform the health care system from within, we must also ask our citizens to reform it from without. The American people themselves can become agents of change, the vanguard of a new health consciousness that will lead to improved health status, a stronger sense of community, and more efficient use of our health care system.

Again, thank you for the invitation to appear before this Committee. I would be delighted to answer any questions.


Births to Unmarried Women (All Races)
30%
25%
20%
15%
10%
5%
0%
70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91
r= 0.99
b= 0.86
• The statistic "r", called the correlation coefficient, indicates how closely a particular regression line fits the data. The 0.99 correlation coefficient indicates an almost perfect fit.
• The statistic "b", called the slope, indicates how rapidly a line is rising or falling.
Births #4


Births to Unmarried Women (All Races)
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
70
71
72
73
74
75
76
77
78
79
80
81
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83
84
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86
87
88
89
90
91
2016
r= 0.99
b= 0.86
• The statistic "r", called the correlation coefficient, indicates how closely a particular regression line fits the data. The 0.99 correlation coefficient indicates an almost perfect fit.
• The statistic "b", called the slope, indicates how rapidly a line is rising or falling.
BirthtoUnmarried Woman2016jr4

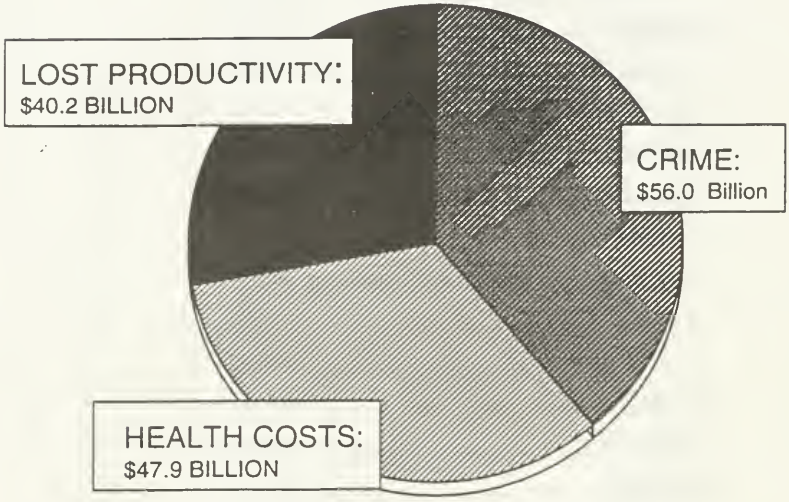
Percent of Births to Unmarried Women (All Races)

1970	10.7
1971	11.2
1972	12.4
1973	13.0
1974	13.2
1975	14.3
1976	14.8
1977	15.5
1978	16.3
1979	17.1
1980	17.8
1981	18.4
1982	19.4
1983	20.3
1984	21.0
1985	22.0
1986	23.4
1987	24.5
1988	25.7
1989	27.1
1990	28.0
1991	29.5

Percent of Births to Unmarried Women 1991 (All Races)

Atlanta	64.4
Baltimore	62.1
Boston	47.3
Chicago	54.7
Cleveland	64.1
Dallas	34.6
Denver	38.4
Detroit	71.0
Houston	26.2
Kansas City	46.2
Los Angeles	47.9
Miami	51.2
Minneapolis	45.7
Newark	64.7
New York City	45.2
Philadelphia	59.4
Pittsburgh	51.9
St. Louis	65.9
San Francisco	31.5
Washington, D.C.	66.3

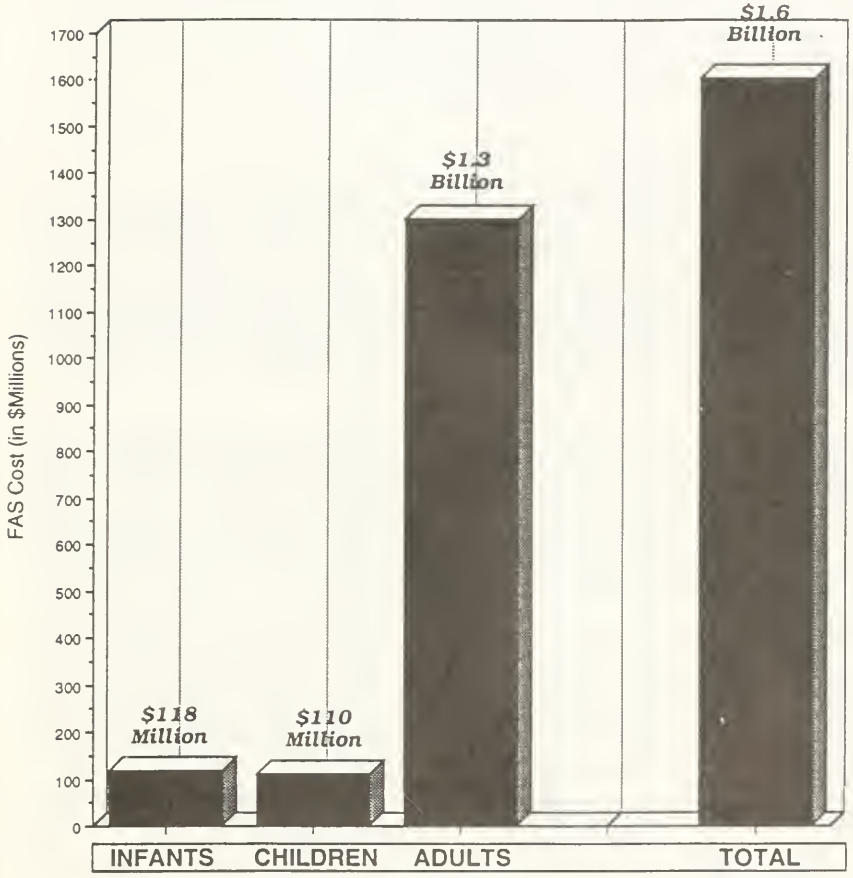
Substance Abuse Costs the U.S. over $144 Billion Each Year



Source: Alcohol, Drug Abuse and Mental Health Administration

Property destruction, law enforcement, auto crashes, premature deaths, health care costs, treatment costs, AIDS, FAS and lost productivity – the $144 billion price we pay for alcohol and drug abuse.

The Lifelong Cost of Fetal Alcohol Syndrome (FAS)



The Lifelong Cost of FAS:

- For INFANTS, neonatal intensive care costs the U.S. $118 million per year.
- Residential care for mentally retarded CHILDREN with FAS adds another $110 million.
- Finally, rehabilitation services and residential care for ADULTS with FAS costs Americans $1.3 billion per year.

With other miscellaneous costs factored in, the bill for FAS comes to a staggering $1.6 BILLION each year.

COMMUNICATIONS

STATEMENT OF THE AMERICAN MEDICAL ASSOCIATION

It is undeniable that the "social behaviors" of individuals in our country have far too significant an impact on health care costs, exert significant pressure upon our health care system and seriously strain many hospital emergency departments. Some of these "social behaviors" are tobacco use, alcohol consumption, other drug abuse, violent acts, unsafe behaviors associated with motor vehicle usage, and unsafe sexual practices. While all of these behaviors contribute to the health care cost problem in this country today, we will focus upon tobacco use, alcohol consumption, and violence.

TOBACCO USE

Tobacco use is the most important single preventable cause of death in the United States. It is a major risk factor for diseases of the heart and blood vessels; chronic bronchitis and emphysema; cancers of the lung, larynx, pharynx, oral cavity, esophagus, pancreas, and bladder; and other problems such as respiratory infections and stomach ulcers. A disturbing trend is that more than half of 8th graders and nearly two-thirds of 10th graders have tried cigarettes. The problem also impacts infants. Between 20% and 30% of the incidence of low birth weight, up to 14% of preterm deliveries, and about 10% of all infant deaths are attributable to maternal cigarette smoking.

The economic costs of tobacco use fall into two categories: direct costs for excess care delivered because of tobacco-induced morbidity and mortality (such as physician office visits, medications, hospitalizations, and surgery) and indirect costs (attributable to lost productivity and wages/taxes, and premature death). The Health Program Office of the U.S. Office of Technology Assessment prepared a report in 1985 that used a wide range of estimates for both direct ($12–$35 billion per year) and indirect ($27–$61 billion per year) costs. Others have estimated direct costs at an even higher rate, as high as $52 billion per year.

Viewing economic costs another way, one may estimate lifetime excess expenditures of current or previous smokers to be about $6,239 per smoker, with a cumulative burden of $500 billion on the U.S. economy. It should be noted that:

- Annual smoking-related health care expenditures by the federal government in 1985 included $4.2 billion in Medicare and Medicaid payments.
- One in five deaths in the United States in 1988 was caused by cigarettes—

  —32% of cancer deaths;
  —21% of coronary heart disease deaths; and
  —88% of chronic lung disease deaths.

ALCOHOL CONSUMPTION

Alcohol dependency and abuse is another major public health problem in the United States. Alcohol abuse generates a large demand on the health care system and the value of reduced or lost productivity is high. Approximately two-thirds of American adults drink alcohol at least occasionally. Of these, it is estimated that about 18 million currently experience problems as a result of alcohol use, and about 7% of drinkers experience moderate levels of dependence symptoms. However, most alcoholics go untreated. In addition, alcohol is a factor in approximately half of all homicides, suicides, and motor vehicle fatalities. Of concern with respect to maternal health, fetal alcohol syndrome affects as many as 3 infants per 1,000 live births in some hospital reports, making it the leading preventable cause of birth defects. We are concerned about the future when today nine out of ten high school seniors report using alcohol at least once.

Again, the following statistics are telling:

- Epidemiological data indicate that 25% to 40% of people in general hospital beds are being treated for the complications of alcoholism.
- Direct treatment costs for alcoholism amount to about $13.5 billion a year; the majority of treatment is administered through general medical care.
- Measurable direct costs of alcohol abuse (medical expenditures on specialty institutions, short-stay hospitals, nursing home care, physician and other professional services, prescription drugs, and support costs) were $6.8 billion in 1985.
- Core costs (direct and indirect health-related costs) accounted for $58.2 billion in 1985.
- Total economic costs of alcohol abuse amounted to $70.3 billion in 1985.
- The proportion of traffic crash deaths that were alcohol-related was 41% in 1988.
- Estimated annual treatment costs for persons affected by fetal alcohol syndrome are $1.6 billion.
- 60% to 90% of all liver disease is alcohol-related.

VIOLENCE

The incidence of violence and abusive behaviors has been increasingly recognized as an important public health problem because of its growing prominence as a source of health care expenditures experienced by Americans. Specific acts of violence not only severely affect the physical health of Americans but also impact the emotional well-being of all Americans. Injuries resulting from violence exact a heavy economic toll, both in direct medical costs and in foregone job productivity. Hospitals also encounter difficulties because many victims of violence who are admitted are uninsured and, in some locations, account for a significant portion of uncompensated care. These victims often require specialized, technology-intensive care. It is horrific that:

- Over 500,000 emergency department visits are due to violent injury.
- Hospital costs related to firearm injuries add an estimated $429 million to health care costs each year. When ambulance services, physician fees, rehabilitation and long-term care costs are included, total medical expenditures for firearm injuries reach an estimated $1 billion per year.
- Fatal assaults in the U.S. added $210 million in direct medical costs in 1985.
- Each year between 1979 and 1986, more than 2.2 million people suffered nonfatal injuries from violence, of which 1 million received medical care and 500,000 were treated by emergency medical facilities.
- In 1985, the direct medical costs of all violent injuries added $5.3 billion to U.S. health expenditures.
- The total lifetime economic cost of injuries which occurred in 1985 include $45 billion of direct costs, most of which are medical costs.
- The average total economic cost of a hospitalization for an injury resulting from violence in 1985 was $34,000.
- Homicide is the 11th leading cause of death in the United States, accounting for nearly 21,000 deaths in 1987.

CONCLUSION

Premature death and disease are caused primarily by "social behaviors" such as alcohol abuse, tobacco use and violence. Of the approximately two million American deaths each year, half are premature deaths, in the sense that they could have been postponed. Nearly 500,000 premature deaths each year are attributable to tobacco use. Another 100,000 are linked to the abuse and misuse of alcohol. These two factors alone account for 60% of all premature deaths.

The AMA is extremely concerned about the harmful and destructive social behaviors so prevalent in our society today and about the impact they exert on our health care system. We have worked hard to bring about changes for the better, and we continue to do so. We are working for a tobacco-free society by the year 2000; for a reduction in alcohol dependency and abuse; and for a curbing of domestic violence, television violence, and violence associated with the use of firearms.

Physicians also are responding to the signs of violence their patients might exhibit. We commend the Committee for its interest in this issue, and we pledge our continuing support for efforts to substantially diminish the myriad of negative social behaviors which, on a daily basis, do so much damage to the very structure and fabric of our society.

ISBN 0-16-044727-5