MEMBERS PRESENT: Chairman Bennett
Vice Chairman Chaney
Mr. Bergevin (late)
Mrs. Ham
Mr. Nicholas
Mr. Thompson

MEMBERS ABSENT: Mr. Mello

Chairman Bennett called the meeting to order at 5:05 p.m. and informed the committee that, since there were people present to testify on ACR 47 that had to leave for Las Vegas, they would hear ACR 47 first.

ACR 47: Recommends procedure for distribution of money received as federal block grants for health programs.

Ms. Marlayn Morrison appeared on behalf of the Vegas Verdes Clinic in order to support ACR 47 which would require the continuation of funding for the community health centers by the state if the proposed federal block grant to the state does take effect. She explained that the block grants as proposed by the Reagan administration would consolidate some 40 categorical health and social services programs; would repeal the statutory authority for nearly all categorical programs and replace it with the broadest possible authority giving states almost complete discretion in spending these grant dollars with no mandate to continue the funding for specific programs under that consolidation. She added that this would mean that programs could be drastically reduced or even eliminated in the state's efforts to balance their own budgets.

Ms. Morrison defined a community health center as an entity which either through its staff or through cooperative arrangements with other entities provides primary health care services including services of physicians, physician's assistants, nurse practitioners, diagnostic laboratory work, radiology services, preventive health and dental services, emergency, pharmacy, transportation and education, as well as referral services for patients to other specialists not in the clinic.

As for the history of community health centers, Ms. Morrison noted that these centers began as neighborhood health center programs, pilot programs under the Office of Economic Opportunity in 1965. These programs embodied many of the dreams and concepts of the war on poverty by addressing the financial and non-financial obstacles standing in the way of improved health in poor neighborhoods. She indicated that this concept sought

to improve the health of the poor by giving residents access to comprehensive health care services and local facilities and was based on several principles:

1. The centers must be located in areas with a high concentration of poverty.

2. They should integrate and coordinate their services with existing health facilities and other community services.

3. They should provide personal, high quality health care.

4. Members of the community served should participate on the governing bodies.

5. Employment opportunities and training programs should be provided to the community residents.

Ms. Morrison continued saying that gradually beginning in 1967 the responsibility for these centers came under the direction and jurisdiction of HEW; that through evolution the primary focus shifted from this multi-faceted approach to a more narrow scope with emphasis on traditional medical care which in effect classified them as poor people's medicine and guaranteed the almost complete dependence of these programs on public funds. She indicated that the clinics use a sliding fee scale which allows the individual to pay for medical care based on their ability to do so and thus maintain their dignity.

As described by Ms. Morrison the effectiveness of community health centers since they were established in 1965 is evidenced by the following findings:

1. Improved access to care.

2. Changed patterns of utilization.

3. Utilization of preventive and health maintenance services.

4. Reduced hospitalization through improved health and better access to primary health care resulting in direct savings to Medicare, Medicaid and county hospitals.

5. Reduced infant mortality and premature births.

6. Increased volume of service by more than 200 percent with only a 20 percent increase in grant funding.

Ms. Morrison commented in discussing community health centers with Senators Laxalt and Cannon and Congressman Santini, she found all three very supportive of these centers.

Ms. Morrison noted that community health centers do not interfere with or duplicate the efforts of other private practice providers; that these centers are located in areas where there is a shortage of health care providing both appropriate and vitally necessary health care. She indicated that the federal support received

by the centers is used to subsidize the cost of care for indigent and uninsured persons; that early intervention allows people to be treated in a lower cost setting prior to their health care needs reaching an acute stage.

Referencing a packet of letters submitted to the committee some months ago, Ms. Morrison noted support from the Clark County Medical Society, Nevada Professional Standards Review, the Nevada Hospital Association, Department of Human Resources, and from various city and county commissions.

In conclusion Ms. Morrison asked the committee's support for ACR 47 to assure the continuation of the funding for the community health centers.

In response to Mrs. Ham's question, Ms.Morrison indicated that there are presently five community health centers in the state entirely federally funded. In answer to Mrs. Ham's further question, Ms. Morrison explained that they are asking for 80 percent of the moneys that were allocated to community health centers in funding year 1981; for the State of Nevada this would be $1.13 million, not 80 percent of the entire $6 million of the block grant.

Ms. Morrison distributed to the committee an Issue Paper on The Effectiveness of Community-based Primary Health Care Centers which is attached as EXHIBIT A.

Bryce Griffith, Administrative Director of the Community Health Center in Reno, said that in looking at community health centers on a cost containment basis there is a very positive advantage to the community health center concept in primary care and preventive medicine being delivered through a family medicine center. He enumerated some of the costs at a community health center: The national average for providing health care at a community health center is $32 per patient encounter; Washoe County's is $21.60. Cost per encounter for a Medicaid patient nationally is $55. He noted that these figures indicate that they are well within a cost containment.

Mr. Griffith advised that what they are trying to accomplish in communities is to provide improved access to low income families, the indigent and senior citizens on a fixed income; that in Washoe County 56 percent of all patients come from medically underserved areas. He noted that their program is not totally federally funded but additional funds come from the university who are strongly committed to community service.

Between Clark County and Washoe County, Mr. Griffith noted there are approximately 90,000 to 100,000 target population; in Washoe County they expect 10,200 users this year or 30,000 actual patient encounters.

Mr. Griffith said that community health centers are needed to provide care for needy populations and urged support of ACR 47.

Diane Guinn, Administrative Director for the Operation-Life CDC Medical Center in Las Vegas, said that they are one of three urban health care projects in the State of Nevada. She said that they were appearing before the committee today because the legislature only meets every two years and because they feel that President Reagan's block grants will become a reality; futher they believe that sufficient future planning will assure that, if block grants are established, continuity of service will not be lost.

Ms. Guinn said that their medical center has been open since January of this year and they are already caring for 300 people a month offering comprehensive out-patient services provided by a full time physician on a sliding scale fee based on ability to pay. She indicated that they are currently preparing to begin construction on a new 10,000 square foot medical facility to house their project which should be completed by February 1982.

In conclusion Ms. Guinn stated that this resolution simply calls for support and endorsement, not necessarily in concrete dollars, but to assure that community health centers will be included in future health budgets as implimented in 1982 and 1983 prior to the next session.

When Mrs. Ham asked how the new facility was to be financed, Ms. Guinn replied that these funds will emanate from private foundation grants, HUD and the city block grant program.

Mr. Nicholas moved DO PASS on ACR 47, seconded by Mr. Thompson and carried unanimously by the members present with Mr. Bergevin and Mr. Mello absent at the time of the vote.

AB 642: Regulates sale of dimethyl sulfoxide in small lots.

Mr. Al Edmondson, Commission of Food and Drugs for the State of Nevada, testified in support of AB 642 indicating that dimethyl sulfoxide has been sold around this state and others out of trunks of cars and health food stores. He noted that dimethyl sulfoxide first came on the market in the early '40's as an industrial solvent, that it is a bi-product of paper mills, but has been advertised as a pain killer and a cure for arthritis. He explained that it costs approximately 75 cents a gallon to manufacture but it is being sold at $20 for an 8 ounce bottle; that it is a commercial, solvent grade product that can contain many contaminants including lead. He indicated that dimethyl sulfoxide is very penetrating, that a drop on the finger can be tasted in seconds, and because it is so penetrating it can carry lead or other contaminants into the blood stream.

Mr. Edmondson said that what this bill will do is hopefully slow down this type of sale; presently the Food and Drug Administration has allowed the sale of DMSO as a prescription drug for cystitis and for veterinary use. He noted that AB 642 will

require a person to purchase a gallon or more at $320 per gallon which will decrease the usage, but it may still be prescribed by a doctor; if bought in smaller quantities, an affidavit must be signed which will additionally decrease the usage. Mr. Edmondson explained that it is very difficult to make this type of product illegal because it does have many commercial uses, and he supports AB 642 because he feels this bill will act as a deterent to the sale of DMSO for other than commercial use.

In response to Mrs. Ham's question, Mr. Edmondson said that DMSO is given by injection in the case of cystitis; that commercial grades are apt to contain contaminants, but when prescribed by a physician, is a pure product.

When Mr. Thompson asked who would enforce this, Mr. Edmondson replied that this would come under the Food and Drug Act which is enforced by the Health Division.

John Polish, Assemblyman District #35 representing White Pine and Lincoln County, asked for support of AB 642. He distributed information obtained from a drugstore that dispenses DSMO for veterinary use and by prescription which is attached as EXHIBIT B. He noted that this literature also included uses and warnings of the side effects of DMSO. He indicated that DMSO is a good product if used under medical direction and by prescription, but hopefully this bill will deter the use of the commercial grade which can be contaminated.

Mr. Joe Midmore, representing the Nevada State Board of Pharmacy, said that they take a neutral position on AB 642 but suggested a minor amendment of adding the word "sworn" on line 10, page 1, before "affidavit" and adding paragraph 4 which would read "4. Anyone giving a false affidavit is guilty of a violation of this chapter." He indicated that with these amendments if someone does misuse DMSO, then the law would have two shots at them, one under a perjury statute and one under this law.

Mrs. Ham asked what the penalty would be for violation of this measure, and Mr. Midmore said it would be a gross misdemeanor which is a fine of $1,000.

Mr. Rick Pugh, Executive Director of the Nevada Medical Association, indicated support of the bill and the suggested amendments.

SB 406: Makes various changes in licensing for emergency medical services and establishes intermediate level of emergency medical technicians.

Ms. Reba Chappell, Chief of Emergency Medical Services for the State Health Division, said that the original bill had a great deal of extraneous matter in it and a subcommittee was appointed to study changes which she chaired. She indicated that the amended version, a result of this subcommittee, was the bill under consideration presently.

Mr. Bergevin questioned if this bill would allow the paramedics to do what AB 304 allowed them to do, and Ms. Chappell referred him to page 4, lines 38 through 46 and read that section. She noted that this wording has been agreed to by the State Board of Medical Examiners, the State Board of Pharmacy, the State Board of Nursing, State Medical Association and the State Hospital Association.

In response to Mr. Thompson's question, Ms Chappell said that they were proposing to amend SB 406 by adding the words "biennially thereafter" after renewable on page 2, line 2; that these words were omitted by the bill drafter. She added that lines 35 through 38 should be deleted because it is a duplication of lines 30 through 34.

Jim Begbie, Health Analyst with the Washoe County District Health Department, said that he served on the subcommittee chaired by Ms. Chappell and offered his support for this measure. He also commended Ms. Chappell for her time and effort on this bill.

Georgianne Green, State Board of Nursing and a member of the Nurses Association, said that both these organizations were in support of this bill as amended. She said that they have worked with Ms. Chappell as well as the nurses who give advanced emergency care and have regulations by the State Board of Nursing ready to be implemented. She enumerated several strong points of the bill: 1) It exempts licensure as an attendent only to registered nurses; they feel that LPN's do not have the substantive background and information on which to practice without having further training as an EMT; 2) RN's will fall under the regulations of the board; 3) The bill says "may perform" rather than "shall perform" which is helpful for people who refuse to perform certain functions; 4) This bill does not limit nurses to just paramedic duties.

Mr. Green distributed a letter of support from a Registered Nurse involved in pre-hospital emergency care which is attached as EXHIBIT C.

Mr. Thompson moved DO PASS AS AMENDED on SB 406, seconded by Mr. Nicholas and carried unanimously by the members present with Mr. Mello absent.

SB 412: Makes various changes to provisions on planning for health care.

Mr. Frank Holzhauer, Chief of Planning for the Department of Human Resources, apologized for Ace Martelle not being present because of personal matters and read his prepared testimony which is attached as EXHIBIT D.

Mr. Nicholas stated that in the past he had served as an administrator under NRS 439A but that he intended to vote unless there were objections from the committee.

Mr. Nicholas noted on page 4 a reference to health systems agencies, and in light of a block grant situation there may be a change in their status. Mr. Nicholas wondered for this reason if this language should be included. Mr. Holzhauer said that at this point in time they are still operating under the Health Planning Act and until this Act is either amended or repealed, they must comply with the Act which calls for health systems agencies. He added that the latest word from the Federal Government on block granting implies that some funding will be earmarked for planning.

When Mr. Nicholas asked if there were any states who were not in compliance with federal law at this time, Mr. Holzhauer said there were probably half or more. Mr. Nicholas then asked if any of these states had any of their funds cut off, and Mr. Holzhauer said not to his knowledge, but the Secretary of Health and Human Services had, and still has, up until January the option to cut off funds, but in January the law changes and he must cut off funds.

Mr. Bergevin suggested amending the bill on page 4, line 37 by deleting the words "the federal act" and inserting "of this Chapter" and doing the same thing on line 41 and on page 2, line 5. Mr. Holzhauer said that they would oppose this amendment because, in order to do that, they would have only this act which would have to completely rewritten to comply with the federal statute. He noted that SB 412 currently states that they implement a federal act which is a huge document with many items that are not specified in SB 412.

Mr. Fred Hillerby, Executive Director of the Hospital Association, said that historically the hospitals in Nevada have supported health planning based on community involvement. He indicated that in the past they have supported the concept of health planning, but now, in times of change, this support must be reevaluated. He noted that health planning has been an attempt to regulate health care, not an attempt to make for good planning. He added that nationally it is felt that health planning has not worked because they see so cost savings; that after ten years cost savings should have been realized. Mr. Hillerby felt that the reason for this was that the attempts in the state to be community based have been frustrated because of the national interference with guidelines that must be followed. He noted that it is difficult to relate directly to the problems of a rural state such as ours and of a rapidly growing state such as ours when the guidelines tend to address the large populated areas of the country.

Mr. Hillerby continued by saying that in this state over $300,000 a year has been spent on health planning and unfortunately, primarily because of federal intervention, it has become a "paper tiger" which has done little to improve the health care system.

Because of federal proposals which call for phase out of health planning over the next two years, Mr. Hillerby felt that there were two options:

1. Continue to try and update state law to be in compliance with the federal statutes and regulations with the knowledge that the funding will disappear before the law expires.

2. Although it is too late in the session, try to develop a health planning law pertinent to this state and not follow the guidelines set down by the Federal Government.

Mr. Hillerby distributed proposed amendments to SB 412 a copy of which is attached as EXHIBIT E. He indicated concern that as the money goes away before the statute does the state is left with following federal guidelines, and removing this stipulation and making the agency responsible for a statute that the legislature has agreed upon makes more sense.

Mr. Hillerby suggested deleting reference to fees because the process of collecting these fees is more expensive than the fees that are charged.

He noted that the law delineates the various activities that require a certificate of need, but that lines 30 and 31 on page 5 say carry out those functions unless the regulations are changed. He felt that statutes set the law and agencies have the authority to adopt regulations to administer that law, not to change it.

Mr. Hillerby asked for favorable consideration of his suggested amendments even though he recognized the threat of withholding of federal dollars. He said that he did not think this would happen because the law will expire in 1982, there are about 30 states not complying and dollars will not be taken away from needy people.

Mr. Nicholas wondered if Mr. Hillerby's organization would assist if there were problems with the Federal Government. Mr. Hillerby indicated that they are in contact with the secretary at present and feel that it is not the intent of the Reagan administration to pursue this.

Mr. Bergevin wondered if some language could be inserted in this bill to the effect that, if federal funds cease, this law becomes inoperative. Mr. Hillerby suggested a sunset provision. Mr. Bergevin agreed that exemptions to the law are not made by regulations.

Mr. Ken Newcomb, Director of the Greater Nevada Health Assistance Agency, felt that health planning, as well as regulation of health care in Nevada as we know it today, is important to continue. He indicated that if this bill was tied solely to the federal act there would be a time of great boom in the health care

without any controls. He said that it was important to keep health planning and review until the next session. He indicated surprise at the discussion of charging fees because almost every agency or division of government charges fees to defray costs. He added that many volunteers are used in the local health systems agencies and that this local involvement is a primary prerequisite to be continued. He agreed with Mr. Hillerby in that health planning has not proved to be cost effective, but the original intent was not to contain costs but to articulate health needs in the state; that health planning has improved access to primary health care, decreased duplication of services and called attention to major issues and problems providing exchange of ideas and information.

Mr. Newcomb stated that Nevada has the highest cost of health care in the nation and there is an on-going need for health care planning by looking at the positive benefits of locally based community health planning.

In regard to the suggested amendments, Mr. Newcome said that deleting "the Federal" would be institutionalizing health planning in Nevada. He indicated that he felt that fees were important and should be continued; that the legislature should set policy and should not allow the Administration exceptions to the law.

Mr. Hillerby noted that lines 7 through 9 state "the amounts of any such fees must be based upon the department's costs of examining and acting upon the applications." He questioned what would happen, since there is $17,000 budgeted for the fees, if there were only four applicants; will the four share the cost of $17,000?

Ms. Myrl Nygran said that they have budgeted $17,000 in anticipated fees; for each of these dollars they receive $3 to support the program. However, if they do not collect the $17,000, she indicated they would not be able to spend the $17,000 or the extra dollars from the Federal Government. She noted that they are allowed only to spend the money that is available.

Mr. Holzhauer said that NRS 439A currently states that the State Department of Human Resources may have a health planning agency, not that they must; if federal dollars are not available the director may choose not to keep this agency. He also commented that the CON is not the heart of the program, that something less than a third of the funds spent go to this program.

Since there was no one present to testify on AJR 43 or SB 500, Chairman Bennett directed attention to AB 654.

AB 654: Makes certain changes in accounting procedures related to public health.

Dr. John Carr, Health Division, said that this bill emanated 277

from a Legislative Counsel Bureau audit and is essentially cleanup language. He noted that NRS 353.321 requires that funds be classified, and NRS 353.323 gives definition to the meaning of these funds. He said that on page 1, lines 7 and 8, the present language "credit of a fund" is not good enough and will be changed to "special revenue funds." He said that the other changes are minor language changes.

Mr. Bergevin moved DO PASS on AB 654, seconded by Mr. Thompson and carried unanimously by the members present with Mr. Chaney and Mr. Mello absent.

AB 107: Revises provisions relating to state assistance in constructing health facilities.

Myrl Nygran, Office of Health Planning and Resources, said that AB 107 is cleanup language to accomodate the requirements of the public bill 93641 in place of the Hill-Burton Act which was established to provide loan grants to hospitals in need of updating and building. She said that under NRS 449 there was a health facilities advisory council established to make determination of where federal grant funds should go; with the passage of public bill 93641 and Chapter 439A the responsibility now rests in the Office of Health Planning and Resources. AB 107 merely makes this portion of the law consistent with Chapter 439A.

Mr. Nicholas moved DO PASS on AB 107, seconded by Mr. Thompson and carried unanimously by members present with Mr. Mello absent.

Since there was no further testimony, Chairman Bennett said that the committee would take action on a few bills.

AB 267: Requires report of complications of abortion.

Mr. Nicholas submitted proposed amendments to AB 267 which are attached as EXHIBIT F.

Discussion revealed that this bill applies to abortions done outside of a hospital.

Mrs. Ham moved DO PASS AS AMENDED, seconded by Mr. Thompson and carried with Mr. Nicholas, Mr. Thompson, Mrs. Ham and Mr. Bennett voting yes and with Mr. Changey and Mr. Bergevin voting no. Mr. Mello was absent at the time.

Mr. Nicholas indicated that he might vote against this bill on the floor, but he did want this bill to reach the floor in light of the other bill that is pending; that he prefers AB 267 to the bill that passed today.

AB 642: Regulates sale of dimethyl sulfoxide in small lots.

The committee reviewed the suggested amendments to AB 642: Insert the word "sworn" before "affidavit" on page 1, line 10; add subsection four reading "4. Anyone giving a false affidavit is guilty of a violation of this chapter."

Mr. Chaney moved DO PASS AS AMENDED on AB 642, seconded by Mrs. Ham and carried unanimously by members present with Mr. Mello absent.

Mr. Bergevin asked Chairman Bennett to hold SB 412 until he talked with Mr. Daykin.

Since there was no further action to be taken, Chairman Bennett adjourned the meeting at 7:30 p.m.

Respectfully submitted,

Patricia Hatch
Secretary

ASSEMBLY

AGENDA FOR COMMITTEE ON Health and Welfare

Date Tues, May 26, 1981 Time 5:00 pm Room 316

Bills or Resolutions to be considered	Subject	Counsel requested*
A.B. 642-	Regulates sales of dimethyl sulfoxide in small lots.	
A.C.R. 47-	Recommends procedure for distribution of money received as federal block grants for health programs.	
S.B. 406-	Makes various changes in licensing for emergency medical services and establishes intermediate level of emergency medical technicians.	
S.B. 412-	Makes various changes to provisions on planning for health care.	
S.B. 500-	Provides for appointment of additional physician and homeopathic physician to board of medical examiners.	
A.J.R. 43-	Opposes any unnecessary restriction by Federal Government on approval of generic drugs.	
A.B. 654-	Makes certain changes in accounting procedures related to public health.	
A.B. 107-	Revises provisions relating to state assistance in constructing health facilities.	

THIS SUPERSEDES AND CANCELS PREVIOUS AGENDA FOR THIS DATE.

*Please do not ask for counsel unless necessary.

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ASSEMBLY COMMITTEE ON HEALTH AND WELFARE
GUEST LIST

Date: [illegible]

PLEASE PRINT YOUR NAME	PLEASE PRINT WHO YOU REPRESENT	I WISH TO SPEAK FOR	AGAINST	BILL NO.
[illegible]	Dept of Human R[illegible]	X		SB 412
Robin Chappell	State Health	X		SB 4[illegible]
[illegible]	Vegas [illegible] Clinic	X		ACR 47
Bryce Griffith	Univ of Nev Community [illegible]	X		ACR 47
Diane Guinn	Operation Life OEC Medical Cent	X		ACR 47
Ken Newcomb	Greater Nevada USA			SB 412
[illegible] Nygren	ONC	X		SB 412
JIM BEGBIE	WASHOE [illegible]	X		SB [illegible]
Joe Midmore	State Pharmacy Board	X		AB 642

EXHIBIT A

National Association of
COMMUNITY
HEALTH CENTERS, Inc.
1625 I Street, N.W. - Suite 420
Washington, D.C. 20006
(202) 833-9280

ISSUE PAPER

THE EFFECTIVENESS OF COMMUNITY-BASED PRIMARY HEALTH CARE CENTERS

Since the establishment of the Community Health Centers program in 1965, numerous studies have reviewed the effectiveness, efficiency and quality of care rendered by these and other community-based primary health care centers.* The preponderance of evidence and findings from these studies indicate that health centers have achieved a high degree of success in the delivery of efficient, effective and high quality care to medically underserved and disadvantaged populations. The studies show that the health centers have:

- Improved access to care for disadvantaged and underserved populations;
- Changed the patterns of seeking health care among users of the health center;
- Significantly reduced hospital admissions, lengths of stay and inpatient care costs for health center users;
- Improved health status and health outcomes among those who use the health centers.

* For purposes of this paper, these centers -- hereinafter referred to as "health centers" -- include all entities supported in whole or in part by the following federal programs: Community Health Centers; Migrant Health; Rural and Urban Indian Health; National Health Service Corps, Hospital-Affiliated Primary Care Centers; Black Lung Clinics; and Primary Care Research and Demonstration.

A. Access to Care

While the various health center programs have been established in order to focus resources on specific sub-groups of the general population (migrant farmworkers, urban poor, Native Americans, etc.), the respective target populations of these programs have shared many characteristics in common. Generally, the potential clients should be:

- Poor or near-poor;
- Members of racial or ethnic minority groups;
- Unemployed or underemployed;
- Medically unserved or underserved, with no other regular source of care.

Several studies and reports have documented the success of health centers in reaching individuals with these characteristics.

- The Department of Health and Human Services stated that the centers are reaching underserved areas and the populations to be served.
  - -- 80 percent of health center users are members of minority groups;
  - -- 71 percent had incomes under $7,000 in 1979;
  - -- 31 percent of the users have five or more family members;
  - -- only 43 percent of users are entitled to Medicaid coverage;
  - -- 59 percent of those served are women and 41 percent are children under 18 years of age.[1]
- According to DHHS, 60 percent of health center users have incomes below the poverty level; the remaining 40 percent are near-poor or low-income.[2]
- The Congressional Budget Office, using 1974 data, stated that 84 percent of Community Health Center users were black and another 3 percent were non-white.[3]

Studies have shown that the centers reach large shares of their target populations.

- Langston concluded that the centers, on the average, have reached about 67 percent of the eligible populations in their target areas, and that an average of 75 percent of the users consider the center as their usual family source of care.[4]
- Bellin found that one center was the central source of care for 84 percent of its neighborhood residents, and that 78 percent of the residents had visited the center in the previous year.[5]
- Perkins' study of a health center in New Haven concluded that the center's ability to reach its target population was confirmed by the fact that a majority of its users were from the lower socioeconomic portion of the population.[6]

The location of the centers has greatly increased access for their target populations by reducing travel and waiting time.[7] Nearly all health center users find the location and hours of operation convenient.[8] Moreover, health centers have employed community residents to reach out to the target population, and they provide transportation services in order to overcome travel and distance barriers. These services have paid off with increased utilization of center services by the poor.[9]

Some critics have voiced concern that free or reduced-fee care will lead to overuse or abuse by patients. Several studies show that this is not the case with the health centers.

- Davis shows that the number of visits annually by health center users falls well below the national average for all low-income persons, and is lower than the average for high-income persons.[10]
- Salber found that utilization is comparable to that for the general population.[11]

- Strauss and Sparer found that, while utilization of the centers may be heavy in the first months after registration (largely as a result of the backlog of untreated conditions), frequency of use declines at least 50 percent six months after registration.[12]

B. Changing Patterns of Utilization

The increased access to care resulting from the establishment of health centers has also paid off in encouraging center users to reduce their use of more costly, less appropriate forms of episodic care, and to increase their use of preventive and health maintenance services. Several studies have shown that a large proportion of health center users previously used hospital emergency rooms and outpatient departments for care.

- Langston's study of 21 health centers concluded that 25 percent of health center users had no prior regular source of care, and 50 percent had previously used hospital emergency rooms and outpatient departments. (Only one in four users had previously used a doctor for primary care.)[13]
- Bellin and Geiger found, in their study of health care utilization patterns of Columbia Point (Boston) residents, that of the 30 percent of all residents interviewed who claimed no regular source of care prior to the health center's establishment, nearly 75 percent were being reached successfully two years later.[14]
- Bellin, Langston and Gold all concluded that many of the centers' users had formerly used hospital emergency rooms for acute care.[15]

These changed patterns of care can do much to reduce the inappropriate, or unnecessary, use of episodic services, as several studies have shown.

- Hochheiser compared pediatric emergency room visits in an area served by a primary care center before and after the center's opening with emergency room visits in areas lacking such centers, and found a 38

percent reduction in child emergency room visits in the center area, compared with no change in the rest of the city and 29 percent increase by suburban children. Hochheiser concluded that comprehensive care centers can reverse the trend of rising emergency room use.[16]

- More recently, Sussman found that center users in Boston had a significantly lower utilization of the emergency room than a matched group of non-users.[17]
- Moore studied emergency room visits in Boston, where he found that in the first two years of a center's operation the number of emergency room visits remained constant per capita while use in other areas was rising. (He also found that health center registrants were more likely to be using the emergency room as a backup for their regular care than those patients who were not registered at the health center.)[18]
- Eggers also found a significant decrease in the percentage of persons reporting hospitals as their usual source of care after the introduction of a health center, averaging 30 percent in five communities. (The most frequent reason given was shorter travel and waiting time.)[19]

Health center users also show significantly higher use of preventive and health maintenance services than other persons.

- Langston found that center users receive more care for health problems, have more shots and examinations, and require less emergency care than non-center users in the same communities.[20]
- Gorman reported that nearly 40 percent of all center visits were for preventive and health maintenance services.[21]

- Hershey found that a greater percentage of users at a rural health center have had a regular physical examination than is true of the entire target population. Moreover, registered minority groups have fewer chronic conditions than the non-user minority population.[22]

Much of the increased use of preventive services has resulted from effective use of community health workers.

- Kent and Smith reported that 50 percent of prenatal patients were being seen in their first or second trimester in neighborhoods served by community health workers, whereas only 32 percent of the patients in unserved neighborhoods were being seen during these crucial periods. (Chabot later found dramatic decreases in infant mortality rates in these same areas.)[23]
- A study of over 7,000 in California showed that immunization rates were 52 percent higher, physical examinations were 32 percent higher and the pap smear rate was 20 percent higher among users served by community health workers than among those not served.[24]

C. Reduced Hospitalization

One well-documented accomplishment of the health centers has been the dramatic reduction of inpatient hospitalization among their patients. No less than seven studies have shown reductions in hospitalization rates among center users ranging from 25 to 67 percent. The savings resulting from these reductions, on the average, has been greater than the annual appropriations for these programs. This is all the more important because most centers do not finance the cost of hospitalization. This reduction is not the result of a financial self-interest by the centers; rather, the reduction results from improved health and better access to primary care.[25]

- Zwick reported a 25 percent reduction in the rate of inpatient hospital days experienced by users of a health center in the three years subsequent to its establishment.[26]
- Klein showed that the rate of hospital admissions for children using a health center was half the rate for children in the same community who did not receive care from the center. In addition, the user average hospital stay was substantially lower than for non-users, resulting in a 60 percent reduction in hospital days when compared with non-users.[27] (Bellin found similar results in Boston.)[28]
- More recently, Sussman found non-users in Boston had 67 percent more hospital days and 43 percent more admissions than center users.[29]
- A study conducted for neighborhood health centers showed a 34 percent reduction in hospital days for persons served through the neighborhood health centers compared to the national average for the same period of time. That experience is comparable to the hospitalization utilization experienced in a prepaid group practice setting.[30]
- Most recently, Corsica compared hospitalization rates for center users against the general population in nine areas of separate states, and found a 44 percent reduction in hospital admissions, 62 percent fewer hospital days and a 34 percent shorter length of stay for center users.[31]
- An extensive baseline study in 13 communities and a follow-up study in five cities with community-based primary care centers (Atlanta, Kansas City, Boston, Charleston, and East Palo Alto) found that even after controlling for age, race, income, health insurance

status, and illness levels, center users had lower hospitalizations than those who received care from other sources. Users had 25 percent lower hospitalization rates than all others, and 22 percent lower rates than those having a private physician as a usual source of care.[32]

It follows that if health centers do reduce utilization of expensive services, that the cost of operating the centers might be partially or fully offset by the savings realized, with the potential of a net reduction in national health care expenditures.

- Zeppas, using 1975 data, calculated a potential system savings of $287.6 million resulting from the 22 percent reduction in hospitalization noted above.[33] The estimated savings is $91 million greater than the FY 1975 appropriation for the Community Health Center program.
- Garcia projected a savings of $385 million for users of Community Health Centers in 1978 (or $138 million more than was appropriated in FY 1978 for CHCs), using the 34 percent reduction in hospital days cited above.[34]

D. Improved Health Status

Health centers have focused on providing ambulatory, preventive and health maintenance services, with resulting improvements in health status among center users. These improvements have been well-documented in a variety of studies.

- Anderson and Morgan documented dramatic reductions in infant mortality rates in several communities served by health centers.
  - -- In one county, the infant mortality rate dropped by 40 percent over a four-year period following the establishment of a health center, while rates in neighboring counties remained essentially unchanged.

-- In another county, the infant mortality rate for blacks (most of whom were users of the local health center) declined by 38 percent, while the rate for whites actually increased.[35]

- Gold found similar results in New York City, where total perinatal mortality was reduced 41 percent over a four-year period in an area served by a health center.

  -- She also found a 29 percent reduction in the prematurity rate with an associated reduction in neonatal mortality.[36]

- Vaughn found similar results in southern Florida.[37]
- Chabot's study of the Denver neighborhood health center network showed a decline of about 25 percent in infant mortality.[38]

Other studies have shown positive results in reducing other preventable diseases.

- A study published in the *New England Journal of Medicine* in 1973 showed that in the ten-year period between 1960 and 1970 the incidence of rheumatic fever dropped 60 percent in Baltimore communities receiving comprehensive health center services. The incidence of rheumatic fever was three times as high in the rest of Baltimore. The author attributed the decrease to the early detection of streptococcal infections at the centers.[39]
- Westermeyer showed increased utilization of clinic services leading to reduced rates of middle ear infections among Indian patients served by an urban health center.[40]

The health center programs have already been the subject of more evaluations than most other health programs. These studies have shown conclusively that health centers have had a positive effect on the patients they serve.

<u>and have been successful in improving access to care, reducing hospitalization rates, and improving the health of their patients</u>. Particularly in view of the characteristics of those served and the nature of the rural and urban areas in which they operate, the above-noted accomplishments of the centers are indeed impressive.

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KEEPING UP

DIMETHYL SULFOXIDE (DMSO) – renewed interest in old "wonder drug".

DMSO, a drug which generated considerable controversy during the 1960's, is the subject of renewed interest. A widely used industrial solvent, it was first reported to have therapeutic potential in 1964 and was extensively studied during 1964 and 1965, in a variety of ailments ranging from sinusitis to schizophrenia. Because of the poor quality of early investigations and reports of ocular toxicity in laboratory animals, the FDA discontinued clinical trials in 1965. Late in 1966, after reviewing all available data, the FDA decided that further controlled trials were warranted to evaluate it for topical treatment of certain serious conditions for which no satisfactory treatment was then available (i.e., severe rheumatoid arthritis, scleroderma and shingles). When subsequent investigations failed to demonstrate ocular toxicity in humans, in 1968 the FDA loosened its restrictions on clinical testing, and extended testing to include topical treatment of other more benign musculoskeletal conditions and inflammatory diseases, certain mental conditions, and the evaluation of DMSO as a potential vehicle for other therapeutic agents. In 1978, Research Industries received FDA approval to market DMSO for the symptomatic treatment of interstitial cystitis. The same manufacturer's NDA for scleroderma was rejected by the FDA last year. In March, 1980, the FDA requested the Cooperative Studies for Rheumatic Diseases Group (supported by NIH) to organize a controlled, blinded study to assess the efficacy of DMSO in the treatment of scleroderma.

Pharmacology: DMSO is rapidly absorbed after oral, topical or parenteral administration in man, and is distributed throughout the body water. Peak serum levels occur 4 hours after oral administration and 4 to 8 hours after topical application. DMSO is metabolized in man to dimethyl sulfone and dimethyl sulfide. Unchanged dimethyl sulfoxide and dimethyl sulfone are excreted in the urine and feces. A small amount of drug is eliminated through the skin and lungs as dimethyl sulfide.

The pharmacologic actions are reported to include: Membrane penetration, anti-inflammatory effects, dissolution of collagen, peripheral nerve blockage (local analgesia), vasodilatation, weak bacteriostasis and antifungal activity, diuresis, cholinesterase inhibition, muscle relaxation, and cryoprotective effects for living cells and tissues.

Clinical uses: Currently, the only approved indication for DMSO is in the symptomatic treatment of interstitial cystitis (see p. 731c). It is available as a prescription drug for clinical use in certain parts of Europe and South America, and in the U.S. as a prescription veterinary drug for the treatment of acute musculoskeletal injuries, particularly in horses.

DMSO has been used investigationally in treating a wide variety of disorders for which conclusive evidence of efficacy is lacking. The primary focus of this research has been on the topical treatment of various musculoskeletal disorders and related collagen diseases, and as a carrier to enhance percutaneous absorption of other drugs. Applied to the skin as a 50 to 90% aqueous solution or gel, DMSO is reported to be effective in relieving the pain, tenderness, swelling, and muscle spasm, and in restoring limited motion in patients with acute strains and sprains, tendonitis, acute and chronic bursitis, rheumatoid, gouty and osteoarthritis. It is also reported to produce significant improvement in the cutaneous manifestations of scleroderma, especially in healing ischemic ulcers of the fingertips. The mechanism of anti-inflammatory effects is speculative, but may involve stabilization of lysosomes, a counterirritant effect (due to the exothermic reaction in association with water), degradation or alteration of collagen or suppression of fibroblast formation in connective tissue.

DMSO markedly increases the permeability of human skin. The percutaneous absorption and effectiveness of a number of drugs is greatly enhanced when dissolved in solvents containing 60% or more of the drug. DMSO is reported to enhance the effectiveness of: Topical corticosteroids, antineoplastic drugs in the topical treatment of skin cancers and idoxuridine in the treatment of herpes simplex and varicella zoster infections.

Toxicity: Administration results in a characteristic garlic-like taste and odor on the breath and skin, due to the dimethyl sulfide metabolite. The taste is noticeable within a few minutes and may last several hours. The odor may last up to 72 hours. Side effects of DMSO applied cutaneously include erythema, itching, burning, discomfort, and occasional blistering. These effects generally increase with the concentration of DMSO and are the result of vasodilatation. Prolonged use results in maceration, scaling and dermatitis. DMSO has potent histamine-liberating properties at the administration site; wheal and flare reactions were noted when concentrations greater than 70% were applied under occlusion. Other reported side effects include headache, nausea, diarrhea, burning on urination, transient disturbance of color vision, and photophobia. When used as a carrier to enhance the percutaneous absorption of other drugs, DMSO may also potentiate their toxic effects.

Summary: The fact that over a thousand articles have appeared in the world literature and that FDA approval has been granted for only one therapeutic indication in man, emphasizes the importance of adequate controls and the use of accepted experimental methodology in clinical testing. The future role of DMSO as a therapeutic agent can only be clearly determined by further well controlled clinical studies. Because of the existing controversy, the restrictive protocol demands of the FDA for clinical testing, and the lack of profit incentive (DMSO is not patentable), most pharmaceutical manufacturers have lost interest in studying or marketing this drug.

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DIMETHYL SULFOXIDE (DMSO)

Actions:

Dimethyl sulfoxide (DMSO) is a clear, colorless liquid which is miscible with water and most organic solvents. It has a broad range of pharmacological properties which include: Anti inflammatory action, membrane penetration, solute "carrier" across membrane, blood brain barrier penetration, nerve blockade, bacteriostasis, diuresis, cholinesterase inhibition, vasodilation, and muscle relaxation. Although a number of uses have been suggested, FDA approval is only for relief of symptoms of interstitial cystitis.

Metabolized in man by oxidation to dimethyl sulfone or by reduction to dimethyl sulfide. Dimethyl sulfoxide and dimethyl sulfone are excreted in the urine and feces. Dimethyl sulfide is eliminated through the breath and skin and is responsible for the characteristic garlic odor from patients on dimethyl sulfoxide medication. Dimethyl sulfone can persist in serum for longer than 2 weeks after a single intravesical instillation. No residual accumulation of dimethyl sulfoxide has occurred in man or lower animals who have received treatment for protracted periods of time. Following topical application the drug is absorbed and widely distributed in the tissues and body fluids.

Indications:

For the symptomatic relief of interstitial cystitis. There is no clinical evidence of effectiveness in the treatment of bacterial infections of the urinary tract.

Investigational Uses: DMSO has been used investigationally in the topical treatment of a wide variety of musculoskeletal disorders and related collagen diseases and as a carrier to enhance the percutaneous absorption of other drugs.

Contraindications:

None known.

Warnings:

Dimethyl sulfoxide can initiate the liberation of histamine; there has been an occasional hypersensitivity reaction with topical administration. This hypersensitivity has not occurred in patients receiving the drug intravesically. If anaphylactoid symptoms develop, institute appropriate therapy. Some data indicates that dimethyl sulfoxide potentiates other concomitantly administered medications.

Usage in Pregnancy and Lactation: Safety for use during pregnancy has not been established. Use only when clearly needed and when the potential benefits outweigh the unknown potential hazards to the fetus.

Dimethyl sulfoxide caused teratogenic responses in hamsters, rats and mice when administered intraperitoneally at high doses (5 to 12 g/kg). Oral or topical doses did not cause problems of reproduction in rats, mice or hamsters. Topical doses (5 g/kg the first 2 days, then 2.5 g/kg the last 8 days) produced terata in rabbits; but in another study, topical doses of 1.1 g/kg days 3 through 16 of gestation failed to produce any abnormalities.

Mothers receiving dimethyl sulfoxide should not nurse their infants. It must be assumed, although data are lacking, that dimethyl sulfoxide is excreted in human milk.

Usage in Children: Safety and efficacy for use in children have not been established.

Precautions:

Changes in the refractive index and lens opacities have been seen in monkeys, dogs and rats given dimethyl sulfoxide chronically. No ophthalmic changes attributable to intravesical instillation of dimethyl sulfoxide have been reported in patients carefully followed for up to 17 months; nevertheless, full eye evaluations, including slit lamp examinations, are recommended prior to and periodically during treatment.

Liver and renal function tests, and complete blood count are recommended at 6 month intervals.

Intravesical instillation may be harmful to patients with urinary tract malignancy because of dimethyl sulfoxide induced vasodilation.

Adverse Reactions:

The patient may note a garlic-like taste within a few minutes after instillation. This taste may last several hours, and an odor on the breath and skin may remain for 72 hours. Transient chemical cystitis has been noted following instillation of dimethyl sulfoxide.

The patient may experience moderately severe discomfort on administration. Usually this becomes less prominent with repeated administration.

Overdosage:

The oral LD$_{50}$ of dimethyl sulfoxide in dogs is greater than 10 mg/kg. It is improbable that this dosage level could be obtained with intravesical instillation of dimethyl sulfoxide in the patient.

(Continued on following page)

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DIMETHYL SULFOXIDE (DMSO) (Cont.)

Patient Information:

A garlic-like taste which may last for several hours is usually noted within a few minutes of administration. A similar odor on the breath and skin may remain for 72 hours.

Administration and Dosage:

Not for IM or IV injection.

Direct instillation of 50 ml dimethyl sulfoxide solution into the bladder may be accomplished by catheter or asepto syringe and allowed to remain for 15 minutes. Application of an analgesic lubricant gel, such as lidocaine jelly, to the urethra is suggested prior to inserting the catheter to avoid spasm. The medication is expelled by spontaneous voiding. Repeat treatment every 2 weeks until maximum symptomatic relief is obtained. Thereafter, time intervals between treatments may be increased.

The standard dose for instillation is 50 ml. In selected cases where symptomatic relief is not complete, the bladder may be gently distended by gravity instillation with up to 500 ml of a solution. The solution should be prepared immediately before use in a glass delivery vessel, from 1 part DMSO and 1 part sterile water. After retention for 15 minutes the medication is expelled by spontaneous voiding. Discard any remaining solution. A standard 50 ml dose should then be instilled for an additional 15 minutes, followed again by spontaneous voiding. Administration of oral analgesic medication or suppositories containing belladonna and opium prior to instillation can reduce bladder spasm in sensitive patients. In patients with severe interstitial cystitis and very sensitive bladders, the initial treatment, and possibly the second and third (depending on patient response), should be done under anesthesia. (Saddle block has been suggested.)

Rx	Rimso-50 (Research Industries[1])	Solution: 50% In 50 ml

[1] Research Industries, 1847 West 2300 South, Salt Lake City, Utah 84119, 800/453-8432.

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EXHIBIT C

WASHOE MEDICAL CENTER

77 PRINGLE WAY • RENO, NEVADA 89520 • 785-4100/CODE 702

Over One Hundred Years of Community Service

MICHAEL J. NEWMARKER
ADMINISTRATOR

May 26, 1981

Nevada State Assembly
Carson City, Nevada
89701

Gentlemen:

As a Registered Nurse involved both directly and indirectly in pre-hospital advanced emergency care, I support Senate Bill 406.

Bill 406 gives recognition to the valuable service nursing can bring, both in education and patient care in the pre-hospital setting.

Respectfully submitted,

Cheryl Hlaston, RN

Cheryl Hlaston, RN
Director of Nursing
Emergency Department

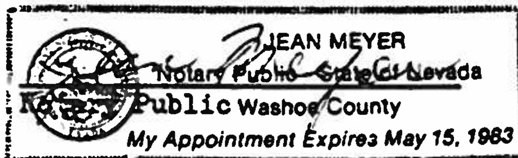
JEAN MEYER
Notary Public - State of Nevada
Notary Public Washoe County
My Appointment Expires May 15, 1983

EXHIBIT D

PROBABLE TESTIMONY - S.B. 412

S.B. 412 amends the State Health Planning Act in order to bring the Act into compliance with the National Health Planning Act of 1971, PL 93-641 and the amendment to this Act, PL 96-79. The State statutes are currently out of conformity with the Federal Act and this bill brings the State law into conformity and assures the feds of our intent to carry out health planning in the state according to the Federal Act. In turn, the Federal government will give the state full designation status. Without a fully designated agency in Nevada, the Secretary of Health and Human Services is required under the Federal law to withhold approximately 9 million dollars in Federal funds appropriated to various state and local agencies under four separate Federal Acts:

1. The Public Health Service Act;
2. The Community Mental Health Centers Act;
3. The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970; and,
4. The Drug Abuse Office and Treatment Act of 1972.

During the last Federal fiscal year--October 1, 1979 to September 30, 1980, Nevada agencies received $9,155,785 under these four acts.

The bill also allows for the collection of fees in the CON Program. These fees have been collected since the first Certificate of Need was required, but because of a lack of specific authority to do so they were halted when advised by the

Legislative Counsel Bureau to do so.

(Let me briefly walk through the bill)

Sec. 1 thru 12 are restatements and clarification of the definitions. This was done to insure the clearest understanding in our dealings with the health care provider and with the many others who come in contact with the agency and to comply with Federal law. Our first thought was to merely regurgitate the Federal law but we thought better of it and attempted to write these in English. This we hoped was the clearest and yet the most precise way of meeting the federal conditions.

Sec. 13 deals with any potential conflict of interest issues on the State Health Coordinating Council.

Sec. 14, 15, 16 & 17 deal with the role and functions of the Council and with the appointment of members. The new language clarifies that areas experiencing shortages of health manpower services will have representation on the Council, the method to be used in appointing replacements to the Council and the duties of the Council. You will note that the duties have been greatly clarified. Most of these changes in the law were recommended by the Federal government and concurred with by the members of the Council.

The major change in Sec. 18 is the addition of the authority to collect fees. As I mentioned earlier, a problem arose last year when the Legislative Counsel Bureau informed the agency that the authority to do so

was not in our law, in spite of the fact that fees had been collected and used in covering the cost of the CON Program for many years. The fees have always been included in the agencies budget and are included in the proposed budget now being considered in the money committee.

Sec. 19 is the State's Certificate of Need statute. The changes being made here are to conform with federal law. The dollar amounts shown are federally mandated. The somewhat extensive new language is necessary so as to eliminate the many problems related to this very controversial program. The remainder of the bill was inserted by the Bill Drafter's Office in order to bring other sections of N.R.S. into conformity with these amendments to 439A.

Once again, the primary purpose of S.B. 412 is to bring Nevada's health planning statute, Chapter 439A, and its program into conformance with Federal statute. Conformance with the Federal Act is critical to the State. Without conformity, the Secretary of the Department of Health and Human Services cannot fully designate the Office of Health Planning and Resources as the State Health Planning and Development Agency for Nevada.

If we do not bring our State law into conformance with the Federal Act with the passage of S.B. 412, the Secretary of the Department of Health and Human Services, in accordance

with the Federal statute, is required to begin withholding Federal funding beginning next year. In January 1982, the Secretary will be required to withhold 25% of the funds covered under the Act; 50% in 1983, 75% in 1984, and 100% in 1985.

In consideration of our present and future budget concerns, and in anticipation that fewer Federal grant dollars for health programs will be available to our State, I sincerely request and strongly urge your support and passage of S.B. 412. This bill has had a number of amendments on the Senate side, and we feel that every effort has been made to accomodate all concerned parties and that the bill should be processed as it reads in the third reprint.

Attached is a listing of those agencies and the funds they have received in FY 80 which would be affected by our failure to pass S.B. 412.

5/26/81

Allotments Subject to Reduction
if no
State Agency Designated

Churchill Council on Alcohol & Other Drugs		$ 50,000
So. Nev. Health Services, Inc.		263,200
Clark County District Health Department		148,070
Economic Opportunity Board of Clark County		245,009
Operation Life Community Development Corp.		209,742
So. Nevada Planned Parenthood		45,260
University of Nevada, Las Vegas		88,768
Central Nevada Rural Health Consortium		301,911
University of Nevada, Reno		2,107,925
Department of Human Resources		4,887,214
Mental Hygiene/Mental Retardation	1,959,106	
Las Vegas Comm. Mental Health Center		
Rural Clinics		
Director's Office	29,684	
Rehabilitation Division	1,545,200	
Health Division	1,184,778	
Office of Health Planning and Resources	168,446	
Western Nevada Community College--South		5,194
Washoe County District Health Department		186,000
Greater Nevada Health Systems Agency		291,090
Inter-Tribal Council of Nevada		32,602
Northern Area Substance Abuse Council		293,800
		$ 9,155,785*

* Federal funds allotted to Nevada under four acts during Federal Fiscal Year October 1, 1979 - September 30, 1980.

PROPOSED AMENDMENTS TO S.B. 412
(Third Reprint)

Amend S.B. 412 as follows:

SEC. 18, page 4, line 37 delete [the Federal Act] and add "this chapter."

SEC. 18, page 4, line 41, delete [the Federal Act] and add "this chapter."

SEC. 18, page 5, line 2 delete [the Federal Act] and add "this chapter."

SEC. 18, page 5, lines 6 thru 9 by deleting the paragraph.

SEC. 19, page 5, lines 30 thru 31 by deleting the new language.

EXHIBIT F

PROPOSED AMENDMENTS TO AB 267.

SECTION 1. Chapter 442 of NRS is hereby amended by adding thereto a new new section which shall read as follows:

Each hospital shall submit a monthly report to the state registrar of vital statistics which contains the following information.

1. The number of patients admitted for hospital care for a complication which resulted from an abortion;

2. The nature of the complication by its diagnostic name; and

3. The type of abortion.

Delete lines 9 and 10 (subsection 4)