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REPORT BY THE

Comptroller General

OF THE UNITED STATES

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The Special Supplemental Food Program For Women, Infants, And Children (WIC)-- How Can It Work Better?

Many local WIC programs provided needed health services and operated as adjuncts to good health care as the Congress intended, but for others this was not the case. Stronger legislative requirements and better administration are needed to remedy this and to prevent further difficulties in providing needed health services as the WIC program continues its rapid expansion. In addition,

--Required professional assessments of applicants' nutritional status were not being made in some locations;

--States used different criteria for judging whether applicants were nutritional risks and eligible for the program;

--Supplemental food packages seldom were tailored to participants' individual nutritional needs;

--Nutrition education and program evaluation have not received the priority and attention they deserve; and

--Program regulations contain provisions hindering effective evaluations.

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COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

B-176994

The Honorable Thomas F. Eagleton, Chairman
Subcommittee on Agriculture, Rural Development
and Related Agencies
Committee on Appropriations
United States Senate

Dear Mr. Chairman:

By letter dated May 11, 1978, you asked us to make a follow-on review of several aspects of the Department of Agriculture's Special Supplemental Food Program for Women, Infants, and Children. As requested, our review centered on the nature and frequency of services provided to program participants, including nutrition education, health services, and the tailoring of food packages to meet participant needs. We also took into account recent program changes included in the Child Nutrition Amendments of 1978 and proposed changes in related Federal program regulations.

As arranged with your office, we will furnish copies of this report to the Department of Agriculture, interested congressional committees, Members of Congress, and others.

Sincerely yours,

Comptroller General
of the United States

COMPTROLLER GENERAL'S REPORT TO THE SUBCOMMITTEE ON AGRICULTURE, RURAL DEVELOPMENT AND RELATED AGENCIES COMMITTEE ON APPROPRIATIONS UNITED STATES SENATE

THE SPECIAL SUPPLEMENTAL FOOD PROGRAM FOR WOMEN, INFANTS, AND CHILDREN (WIC)--HOW CAN IT WORK BETTER?

D I G E S T

The Department of Agriculture's Special Supplemental Food Program for Women, Infants, and Children, administered by its Food and Nutrition Service, ought to work better. Its objective is to improve the health of pregnant and lactating women, infants, and preschool children considered to be at special nutritional risk. Improvements are needed in the program's tie-in to health services, the assessments of participants' nutritional status and related food prescriptions, participants' nutrition education, and the evaluation of the program's results.

Weaknesses in these areas have resulted in some local programs operating mostly as food distribution programs, similar to the food stamp program, without being directly related to participants' health status.

The Congress authorized $250 million a year for the special supplemental food program for fiscal years 1976 through 1978 and has enacted legislation which will steadily increase this amount to $950 million for 1982. Using funds carried over from preceding years, the program used $370 million in fiscal year 1978. (See p. 1.)

BETTER HEALTH SERVICES TIE-IN NEEDED

The Congress intended that WIC operate as an adjunct to good health care. Although participants are not required to receive health services, local agencies operating the program are supposed to make obstetric and pediatric services available to participants as needed.

Many State and local programs have achieved the strong health service element the Congress intended. In other State and local

programs, however, health services were sometimes not available, their availability was not assured, or some participants chose not to use them. (See p. 4.)

Neither the Food and Nutrition Service nor the States took adequate steps to be sure that health services would be available before local programs were approved, or to make sure that once the programs began operating health services actually were available. (See p. 11.) Although weak in in the past, coordination between the Departments of Agriculture and Health, Education, and Welfare regarding the availability of health services seems to be improving but further cooperative efforts are needed. (See p. 16.)

Improvements in coordination and other efforts by Federal, State, and local agencies alone might not be enough to assure that health services are available to program participants. In many communities, adequate health services do not exist or funds are not available to pay for low-income families' health services. Neither HEW nor State programs for extending and expanding health services include plans for an expansion of the size that may be needed. This situation along with the problems the program has already encountered in providing health services to participants, could result in continuing, or increasing the kinds of difficulties the program has experienced in operating as an adjunct to good health care. (See p. 17.)

PROBLEMS WITH NUTRITION ASSESSMENTS AND FOOD PRESCRIPTIONS

For the program to function effectively as an adjunct to good health care, it is essential that each applicant's nutritional needs be determined through a nutritional/health assessment by a competent professional authority. Many local clinics GAO visited were making needed nutritional risk assessments while some were not. (See p. 22.)

Uniform criteria is not used in determining whether WIC program applicants are at nutritional risk. The different rules used by different States result in uncertainties, inconsistencies, and inequities as to the basis for participants' eligibility for the program as well as their specific food needs. (See p. 24.)

Individual food packages are supposed to be prescribed to meet each participant's nutritional needs. With a few exceptions, the local programs were making little or no attempt to prescribe individual food packages. Instead, the maximum allowable standard quantities of all foods were given to nearly all participants. In a few cases, food packages could have aggravated participants' health conditions.

In some cases, food prescriptions could not be made because required nutritional assessments had not been made. In others, WIC agency staff simply were not receiving professional advice to tailor a food package to each participant's health condition and nutritional needs. There was some feeling among local program personnel that because participants are poor they need the maximum quantity of food allowable under the program regardless of their nutritional/health status. (See p. 32.)

NUTRITION EDUCATION NEEDS MORE EMPHASIS

The Congress made nutrition education a part of the program because it wanted participants to be taught what foods were most nutritious and how to include these foods in their daily diets. However, this component has not received the priority that the Congress intended it to have and that it deserves. (See p. 42.)

The Service has not provided sufficiently specific guidance to States on what is required in nutrition education nor made sure nutrition education is an integral part

of local programs. State involvement fell short in important respects. (See p. 42.)

Some local programs had included nutrition education on a well thought out basis. Others, however, offered little or no nutrition education. Generally, no evaluations existed of nutrition education's overall effectiveness in teaching participants how to improve their nutritional status and in getting them to use WIC's supplemental food wisely. (See p. 42.)

The recently enacted Child Nutrition Amendments of 1978 could result in improved nutrition education. Regulations to implement this legislation should help but need revision; other measures also are needed. (See p. 52.)

PROGRAM EVALUATION SHOULD BE IMPROVED

The Congress has emphasized the importance of good program evaluations. However, reliable assessments of the special supplemental food program's overall results and benefits have not been made. (See p. 56.)

The broader evaluations of the program that have been made, while providing some information that may be useful, have not always been reliable. The more limited studies, including those conducted by various States, generally are of uncertain quality and reliability. (See p. 56.)

Although the Service recently took some steps to improve its program evaluations, its regulations contain provisions which could hinder future evaluations--as they hindered GAO's work during this review. These provisions restrict access to program participants' health status information on the basis that the information is confidential. This kind of information is confidential and access to it should be limited and the content safeguarded. But this can and should be done in ways that would not present obstacles to evaluations of program operations and results. (See p. 59.)

RECOMMENDATIONS

The Congress should revise the authorizing WIC legislation to clearly require that participants receive needed health services where such services are available, accessible, and acceptable, with possible exceptions based on participants' religious beliefs. Wording to implement this change is provided in the report. (See p. 19.)

At present, existing program regulations which require that health services be available in an area before a WIC program is approved are not being strictly observed. As part of the oversight of this program, the Congress should monitor the Department of Agriculture's actions on GAO's recommendation that the Department work with the States and local agencies and with the Department of Health, Education, and Welfare to provide needed services in those present and planned program areas where adequate health services are not available, accessible, and acceptable. A problem that must be addressed by the Congress is whether the benefits of the food supplement part of the program alone warrant its expansion to areas where needed health services cannot be delivered.

To improve the program's effectiveness, the Secretary of Agriculture should take a number of actions described in the report addressing: (1) the availability of health services in existing and planned program areas, (2) program coordination with HEW, (3) nutritional risk assessments, (4) tailoring of food packages, (5) nutrition education, (6) program evaluation, and (7) access to medical information. (See pp. 19, 39, 54, and 61.)

AGENCY COMMENTS

Oral comments were obtained from the Department of Agriculture. Agriculture's concerns about GAO's review and some of its conclusions are recognized in the report as appropriate. Written comments from the Department were not received in time to be analyzed and included in the report along with GAO's evaluation.

Tear Sheet

GAO's review results also were discussed with HEW officials and clarifications were made in the report as appropriate. Generally, these officials believe the report raises significant program issues that need attention.

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ABBREVIATIONS

GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare
WIC	Special Supplemental Food Program for Women, Infants, and Children

CHAPTER 1

INTRODUCTION

The Congress created the Special Supplemental Food Program for Women, Infants, and Children (WIC) in 1972 to provide food assistance as an adjunct to good health care for pregnant women, lactating mothers, infants, and preschool children considered to be at special nutritional risk. 1/ It was authorized on an experimental basis on September 26, 1972, as an amendment to the Child Nutrition Act of 1966 (42 U.S.C. 1786). The program's underlying premise is that substantial numbers of children, infants, and pregnant and lactating women from low-income families are at nutritional risk because of inadequate nutrition, inadequate health care, or both. The program, administered by the Department of Agriculture's Food and Nutrition Service, was designed to supplement the food stamp program.

Although the program was not fully implemented until 1974, it has grown rapidly. Its funding level increased from $20 million for fiscal year 1973 to $250 million for each of fiscal years 1976, 1977, and 1978. Recently enacted legislation extends the program and increases the funding level from $550 million in fiscal year 1979 to $950 million for fiscal year 1982--an increase of about 5,000 percent since the program's inception.

According to program officials, program participation increased from 633 participants in 36 health clinics during the first month of operation in January 1974 to over 1.3 million participants--about 287,000 women, 356,000 infants, and 729,000 children--in over 4,800 health clinics as of November 1978. The program is operated by 49 State agencies, 21 Indian health agencies, the Virgin Islands, and Puerto Rico.

Because of the program's rapid expansion, the Chairman of the Senate Subcommittee on Agriculture, Rural Development and Related Agencies, Committee on Appropriations, in a letter dated May 11, 1978, requested that we obtain information on the nature and frequency of services provided to WIC participants, including nutrition education efforts,

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1/According to program legislation, nutritional risk means detrimental or abnormal nutritional conditions, dietary deficiencies that impair or endanger health, or conditions such as drug addiction and alcoholism, that predispose people to inadequate nutrition.

health services, and the tailoring of food packages to meet participant needs. Two earlier GAO reports on WIC 1/ discussed the Department's efforts to evaluate the program's health benefits. A more recent GAO report 2/ addressed the appropriateness of entitlement funding for the WIC program.

HOW THE PROGRAM OPERATES

The WIC program makes cash grants available to participating State health departments or comparable State agencies, Indian tribes, or to the Indian Health Service of the Department of Health, Education, and Welfare (HEW). These funds are used to provide specified nutritious supplemental foods to pregnant and lactating women, infants, and children up to their fifth birthday, determined to be at nutritional risk by competent health professionals (physicians, nurses, or other health officials) because of inadequate nutrition and inadequate income. The funds are also used to pay specified administrative costs, including nutrition education. The estimated average monthly food cost per participant (women, infant, or child) is about $22. WIC agencies can provide the supplemental food directly to participants or can give the participants vouchers or certificates redeemable for the specified foods at retail stores.

The Department of Agriculture is responsible for program administration and evaluation, as well as for accounting for Federal funds expended by State agencies. The States are responsible for selecting local agencies to operate the program and for ensuring that these agencies comply with program regulations. The local agencies are responsible for providing program benefits to participants, including the supplemental foods, nutrition education, and health services. Many of these local agencies receive funds through HEW to administer their programs for expanding and extending health services. Other agencies are operated by the States or are private nonprofit organizations. Health services' costs must be paid from HEW, State, local, or other funds; WIC funds may not be used to pay for health services except for medical tests and, as a result of recent legislation, certain items of medical equipment necessary to determine eligibility.

1/"Preliminary Report on the Special Supplemental Food Program," B-176994, Sept. 28, 1973, and "Observations on Evaluations of the Special Supplemental Food Program," RED-75-310, Dec. 18, 1974.

2/CED-78-98, Apr. 13, 1978.

PROGRAM LEGISLATION

The Child Nutrition Amendments of 1978 (Public Law 95-627, 92 Stat. 3603) was enacted November 10, 1978. This legislation extends certain child nutrition programs under the National School Lunch Act and the Child Nutrition Act of 1966. The law extends the WIC program through fiscal year 1982 and authorizes increased funding levels. It also establishes a national income standard for program eligibility based on income standards prescribed for free and reduced price school meals under section 9 of the National School Lunch Act. Additional provisions include (1) strengthening the nutrition education component of the program and (2) changing the allocation formula for administrative funds to provide for more effective and efficient program administration. This legislation is discussed further in later chapters.

CHAPTER 2

WIC HEALTH CARE ASPECTS NEED TO BE STRENGTHENED

The Congress intended WIC to be closely associated with health care for women, infants, and children but did not specifically require that participants receive needed obstetric and pediatric services. Many of the local programs we reviewed achieved the strong health-service element the Congress intended. This was especially true in Louisiana where the State required that participants at least receive counseling on the health services they needed as a condition to receiving WIC foods. However, some of the local programs did not have strong health care elements and operated essentially as food distribution programs similar to the food stamp program.

WIC participants did not receive health services for several reasons. In some cases, obstetric or pediatric services were not available in the community. In other cases WIC participants chose not to use health services available to them.

Generally, obstacles exist which impede low-income women, infants, and children from receiving obstetric and pediatric care. These obstacles are at the Federal, State, and local government levels as well as in the private health care sector. (The problem of access to health care will be addressed in detail in a forthcoming GAO report.) In this review, however, we found that neither the Food and Nutrition Service nor most of the States we reviewed made adequate efforts to ensure that health services would be available before local programs were approved and to follow up to ensure that the health services actually were being made available once the local programs began operating. Although weak in the past, coordination between HEW and the Department of Agriculture regarding WIC health services seems to be improving.

Although better coordination and other efforts by Federal, State, and local agencies are needed, such improvements alone might not be enough to ensure that health services are available to WIC participants. If appropriate health services, as well as the money to pay for them do not exist in a community, even good management and coordination will not result in a program operated as an adjunct to good health care.

WIC INTENDED TO BE AN ADJUNCT TO HEALTH CARE

The purpose of the WIC program, as stated in legislation, is to provide supplemental nutritious food as an adjunct to good health care during critical times of growth and development to prevent health problems.

The legislative history shows that the Congress was concerned about members of low-income families not receiving good health care or proper nutrition. Proponents of the legislation argued that nutritious food, in addition to good health care, was necessary for proper growth and development. In addition, the proponents envisioned that, since participants would be routinely visiting health clinics in connection with obtaining the supplemental food, they would be treated for medical conditions that otherwise would go untreated.

The legislation, although not requiring WIC participants to receive health services, created a very close association between the supplemental food aspect of the program and health care services. It provided that the program should be operated through State health departments or related agencies capable of providing health care. (Many low-income persons depend on State or local government supported clinics for obstetric and pediatric health care.) The legislation also required that program eligibility, including nutritional risk, be determined by competent health professionals and that the supplemental food be prescribed under appropriate professional guidance in quantities necessary to satisfy individual nutritional needs.

In some States, the local programs we reviewed seemed to be more strongly tied to health services than others--in accordance with legislative intent. Although some aspects of even these programs, as well as the others, need improvement in such areas as food package tailoring and nutrition education (as discussed in subsequent chapters), the health care aspect was strong.

In Louisiana, for example, local WIC agencies were providing various health care services, including routine preventive-type services, such as physical examinations and immunizations. In cases where the local agencies could not provide comprehensive health services, including prenatal and pediatric care, WIC participants were referred to nearby hospitals, nonprofit health clinics, or private physicians committed to providing such care.

As a minimum, participants in Louisiana's WIC program were required to attend counseling sessions with a physician or nurse to discuss their health status. Pregnant women and mothers of participating infants and children were required to be counseled every 3 months on their and/or their children's health status. The children were also given blood tests; height, weight, and head circumference measurements; and immunizations as needed. Although the participants did not actually have to accept the health services, all the participants whose cases we reviewed received them.

If a medical problem is identified during a counseling session, the participant could receive the needed care through the WIC agency or at a nearby health facility capable of providing such care. The outside source has to submit information to WIC personnel outlining the patient's medical problems, describing the planned treatment, and showing whether or not the participant received the necessary treatment. A similar method of feedback is used where participants receive health care from private physicians.

The benefits of Louisiana's health service requirement to the WIC participants were assessed in a survey conducted by the State in 10 local WIC agencies after the first 15 months of program operation. This survey indicated

--a decline in the number of participants suffering from anemia,

--improvement in the recorded heights and weights of WIC participants,

--an increase in the amount of immunizations given,

--more pregnant women coming in earlier for prenatal care,

--a decrease in missed scheduled medical appointments, and

--generally improved health status of the program participants.

In Louisiana, we found that each of the 125 participants (75 women and 50 infants and children) whose cases we reviewed received health care along with the supplemental WIC foods. We also talked with 20 WIC participants to obtain their views on the program's operation. Most of them were satisfied with the health services they received.

Unfortunately, the situation at some clinics in New York, Washington, and Illinois did not show as close an association between WIC and health care as we found in Louisiana.

STRONGER EFFORTS NEEDED TO ENSURE HEALTH SERVICE AVAILABILITY

The Food and Nutrition Service has delegated to the States the responsibility for ensuring that health services are made available to WIC participants, but has not adequately reviewed or monitored the States' activities to ensure they are carrying out this responsibility. Two (Illinois and Washington) of the four States we reviewed were not determining whether local agencies could make health services available before approving them for the program. None of the four States adequately monitored the local agencies after program operations began to see if they were actually meeting health service requirements.

Although the Service had considered ways of strengthening WIC's health service aspect, it took no action to do so. The responsibility for making sure health services are available to WIC participants was delegated to the States without any follow up to see that the States were fulfilling this responsibility. Service officials recently told us that they believe follow up is needed in this regard.

States' approval of local agencies did not ensure health service availability

State agencies are responsible for approving local WIC programs on the basis of Food and Nutrition Service priority criteria and program eligibility standards. In approving local agencies to operate WIC programs, the States are to ensure that the agencies meet all program requirements, including making required health services available for participants' use. This has not been done by Illinois and Washington because of misinterpretation of the Service's regulations. Also as discussed in detail later, two local programs in New York did not have sufficient capacity to make health services available to all participants.

The Illinois State agency has proceeded on the basis that, if medical care providers exist in the community being served by the WIC program, health services are available to the participants. The State has not ensured that specific arrangements, including written agreements, are made with these providers as mandated by WIC regulations and has not ascertained whether participants were able to use the

available services. At two of the programs we visited in Illinois, health services are available in the community but were not available to all WIC participants because of the participants' inability to pay the regular fee for the services.

In the State of Washington, the availability of any health services, even if not of the type required for WIC, is considered by the State WIC coordinator as being satisfactory for meeting the regulations' health service requirements. Under such interpretation, the State agency approved all local agencies that submitted applications, even if only minimal health services, such as family planning or dental care were available. As a result, three of the five local WIC programs we reviewed were approved without the required health services being made available to participants.

According to a Service official, pertinent health services, including prenatal and pediatric care, must be made available to WIC participants. Considering the matters cited above, it seemed clear to us that Illinois, Washington, and New York need to take more effective measures to ensure that the required health services are made available to WIC participants.

Program monitoring has not included health service availability

Although the Department of Agriculture reviews State WIC operations, it has not inquired into whether State agencies are fulfilling their responsibilities for ensuring that local programs make needed health services available to WIC participants. State monitoring of local programs likewise has not covered health service availability.

In 1977, the Service began periodic management evaluations of States' WIC activities but focused on administrative matters, such as participant certification/recertification procedures, food delivery and distribution systems, funds management, reports and records, administrative costs, nutrition education, staffing, training, and civil rights. In the States reviewed we found that assessments of the availability of needed health services were not included in these reviews. Also while the evaluations included the States' general monitoring of WIC activities, they did not give specific consideration to State monitoring of health service availability. Service officials told us that they had delegated the responsibility to the States for ensuring health service availability, and did not monitor these activities.

In addition to the Service's management evaluations, the Department's internal auditors occasionally review aspects of the WIC program. In the past, these audits have concentrated on such program aspects as participant eligibility and various administrative functions. They have not routinely covered health service availability.

The four States we reviewed either were not covering health service availabiliity in their monitoring of local program operations or were not covering it adequately. As discussed earlier, two of the States misinterpreted the requirements regarding health service availability and, accordingly, officials in these States might not have recognized the need for corrective action. However, if the Service had been effectively monitoring this aspect of the program, both the States' misunderstandings and the inadequate local efforts to ensure health service availability could have been detected earlier and steps taken to correct them. We believe it is necessary for the Service to ensure that all WIC program requirements, including health service availability, are being met.

Service attempts at strengthening program's health care aspect

Because WIC program legislation does not require that participants actually receive health services, Department of Agriculture regulations require only that health services be made available. However, Food and Nutrition Service officials have recognized the importance of the program's health care aspect and have tried to strengthen it.

In February 1977, the Service proposed that WIC participants be required to enroll in a health care system as a prerequisite to receiving WIC's supplemental food. Service officials stated that this proposal would have required receipt of health services, rather than mere availability of such services. The proposal's intent was to ensure that the WIC program genuinely operated as an adjunct to good health care as mandated by the authorizing legislation.

According to Service officials, this proposal was not adopted because of the negative reaction received from local program officials and other concerned individuals. The Service received 65 written responses on this part of the proposed regulations, 40 of which opposed the proposed requirement or suggested that participation in health services be encouraged rather than required. Sixteen comments supported the proposed requirement and 9 requested that it be clarified. The reasons for opposition generally were not

stated; the respondents apparently believed that, although health services are important, they simply should not be required as a condition to receiving supplemental food.

Subsequently, in a June 1977 memorandum to all of its regional administrators, the Service tried to provide additional guidance on health services, stating:

> "***providing food efficiently, while important, is not the sole criteria for a successful WIC program. Assuring that recipients receive effective nutrition education and take part in the available health services is just as crucial and should be regarded as one of the major goals of the Program."

Service concern about participants receiving health services, however, has not been enough to ensure that local WIC programs always include a strong health care element.

WIC DOES NOT ALWAYS OPERATE IN CONJUNCTION WITH HEALTH CARE

Although WIC was intended to operate as an adjunct to good health care, participants have not always received needed health services. In the local WIC programs we reviewed

- --health services were sometimes not available or their availability was not assured;
- --some participants apparently chose not to use health services; or
- --we could not determine what services, if any, some participants received because we were denied the information necessary to make such determinations.

Of the 500 cases we selected for review in Illinois, Louisiana, New York, and Washington, we were able to obtain information on the health services provided 393 participants. In the other 107 cases, we could not obtain information on what health services, if any, the participants received. (This situation is discussed further in chapter 5.) Of the 393 cases in which we could obtain needed information, we could find no evidence that 53 participants had received health services. All 125 cases we reviewed in Louisiana received health services--State requirements regarding participants receiving health services are discussed earlier in this chapter.

Service regulations state that local WIC programs "will make health services available to all recipients who participate in the program." If health services are to be made available through private physicians or other sources outside the local WIC agency, the regulations require that written agreements be entered into with the sources of such services to assure that the health services actually will be available. Also, the Service believed that for the program to be an adjunct to good health care, requirements were needed regarding the type of health care to be made available. Accordingly, "health services" as defined by the regulations means ongoing routine pediatric and obstetrical care, such as infant and child care, prenatal and postpartum examinations, nutritional examinations or screening, diagnosis, and treatment or referral for treatment. According to Service officials, if these services are not available to participants who need them, the health service aspects of the program are not being met.

Local programs were not taking adequate steps to make health services available to WIC participants

Of the 20 local WIC programs reviewed in four States, 6 in the States of Washington and Illinois did not make all the required health services available to all WIC participants either internally or through written agreements with outside sources. Two of these six programs offered pediatric services but no prenatal services; the other four did not offer either prenatal or pediatric services--the two most important services for the program's target population. Five of the programs offered informal referrals to private physicians and/or other medical facilities. The local WIC programs we visited in New York and Louisiana made health services available to WIC participants; however, as discussed later in this chapter, two local New York WIC agencies did not have sufficient resources to serve all of their participants. (See p. 13.) Most of the participants from these six programs whose care we reviewed were left on their own regarding health care and had to make their own arrangements for any health services they needed.

One WIC program in Washington had a caseload of about 1,000 participants and, at one time, offered a fairly wide range of health services. However, about 4 months before our visit, the entire medical staff resigned, leaving only administrative and dental services available to participants. The program's former medical director told us that no other opportunity for health care existed in the area for most of the program participants. We found no indication that any

of the 25 participants whose cases we reviewed were receiving health services. The 1,000 program participants simply were given WIC food during this period.

Another WIC program in Washington, with a caseload of about 960 participants, offered only family planning services. A local program official said that private physicians were providing the participants with needed health services, but no written agreements existed to ensure that such services actually would be available. We could not check whether participants actually were receiving health services because a local program official would not tell us the names of the physicians supposedly providing the services. Local WIC program staff had not verified whether WIC participants actually were receiving health services.

Only pediatric services were provided for 834 participants at one Seattle, Washington, program. This program had 102 pregnant women needing prenatal services. According to a program official, they simply gave participants needing prenatal services the names of private physicians who might provide the needed services. The participants then had to arrange for their own health care. Of 15 adult participants whose cases we reviewed, we could not determine what, if any, health services 9 were receiving because the private physicians would not provide us with the information. The other six were receiving the type of health services their WIC status appeared to indicate, as were the 10 infants and children whose cases we reviewed.

Two Illinois WIC programs with caseloads of 624 and 1,655 participants did not offer either pediatric or prenatal services. Program officials said that referrals to private physicians generally were made but that there was some reluctance on the part of private physicians to accept medicaid patients. (All WIC participants must meet an income level requirement established by State agencies and many rely on medicaid to pay their medical expenses.) Of 25 participants whose cases we reviewed at one of these programs, we could find no indication that 11 were receiving health services. In the other program, 24 of the 25 participants whose cases we reviewed were receiving health services. Because neither of these programs had written agreements with private physicians or other outside health service sources--as required by WIC program regulations--the availability of health services was not adequately assured for participants referred to such outside sources.

Insufficient capacity sometimes limited availability of health services

Of the 20 local WIC programs we visited, 14 made pediatric and prenatal services available to WIC participants at their own clinics or through written agreements with other sources. However, two of these programs in New York, with WIC caseloads of about 2,700 and 560 participants, did not have the capacity to allow the services to be available to all the participants they enrolled.

At one of six WIC sites operated by one of the New York programs, health services were provided by the sponsoring hospital. Although there were 129 women enrolled in WIC at this location, the maximum number of women participants the hospital could private with prenatal care was limited to 60, including both WIC and non-WIC pregnant women. According to a program official, prenatal care could not be provided to more women without placing an undue burden on the facility and its medical staff. Of 15 adult cases we reviewed at this location, we could find no indication that 5 participants were receiving any care. Of the remaining 10 cases, 3 were receiving care at the hospital and 7 were receiving care from other sources. The nine infants and children whose cases we reviewed all received pediatric services.

The other program--with about 560 participants--had constraints on its pediatric care. Because of insufficient capacity, there was about a 2-month waiting list for pediatric care, including both WIC and non-WIC patients. However, in 9 of the 10 infant and children cases we reviewed at this program, the participants had received health services either from the WIC agency or from other sources. The remaining one was a new-born infant.

Health services are not always used

Some of the 53 participants in our sample who apparently were not receiving health services actually had health services made available to them through their local WIC programs. Under program regulations, participants may, at their discretion, take advantage of available health services, obtain such services from other sources, or use none at all, as illustrated by the following cases.

--In four cases, WIC records showed that two hospitals were providing the women participants with prenatal care. However, when we asked the hospitals whether

the women were actually receiving such care, they could find no records of the four participants receiving any care.

--A woman who had participated in the program for 8 months received only an initial prenatal check. Clinic officials had no information as to whether or where the participant was receiving prenatal care.

--A woman had received only an initial prenatal checkup and had not returned for health services for her remaining 5 months of pregnancy. Clinic officials had no other information relating to the participant's prenatal care.

If WIC participants continue to receive WIC food packages each month without receiving needed health services, WIC essentially becomes simply a food distribution program--like the food stamp program--instead of the broader, more comprehensive health-related program the Congress intended.

AGRICULTURE-HEW COORDINATION HAS BEEN WEAK BUT SEEMS TO BE IMPROVING

Coordination between the Departments of Agriculture and HEW, and between State and local personnel administering WIC programs and various HEW health service programs, shows signs of improving. One problem has been that Agriculture and HEW have different views on what kinds of locations should have the highest priority for receiving WIC programs. Also, some locations do not have WIC programs because of difficulties in finding a suitable local organization or agency to administer the program or in making arrangements for prospective participants' health services.

Although State and local governments provide much of the health care to low-income families, Agriculture and HEW could insure greater access to health care for WIC participants through closer coordination. Agriculture and HEW have recently undertaken discussions and studies on where WIC programs should be started and on various other policy questions affecting WIC. Improved coordination in such matters are critical if the program is to operate as an adjunct to good health care and if it expands as anticipated.

HEW-funded health programs and WIC are not always in the same areas

A location's priority for receiving WIC may differ from its priority for receiving HEW funds because (1) the two Departments disagree as to where these programs should be started first and (2) because HEW has broader health program objectives.

HEW officials believe WIC is not operating as an adjunct to good health care because, in many instances, it is operated by clinics offering only diagnostic and screening services rather than the wide range of health services needed by WIC participants. As discussed earlier, arrangements for participants' health care outside the agency operating the program sometimes are not reliable. HEW officials believe the WIC program should be operated only in areas which have local health agencies offering health care to mothers and children.

Many local health clinics and agencies receive part of their start-up and operating costs from HEW to administer various HEW health programs. Several of these HEW-funded programs are designed to provide health services, including pre-and post-natal care, to persons otherwise lacking access to such services, especially members of low-income families. The two major programs are

--the Maternal and Child Health Program designed to reduce infant mortality and promote the health of mothers, infants, and children of low-income families and

--the Community Health Centers Program which is designed to provide a broad range of health and social services, including maternal and child health care, to areas lacking adequate health care.

Individuals eligible for the WIC program would be eligible for these HEW programs; therefore, HEW officials believe the clinics receiving these HEW funds should also be operating WIC programs.

Agriculture has said that the HEW-funded clinics are not always in the areas most needing WIC, and that WIC programs should be started in areas needing them most even if no clinics are operating there. It believes a WIC program without a health care component in such areas is better than nothing and that the lack of health services is one reason why the areas need a program.

HEW and Agriculture criteria for allocating their respective program funds to various locations are basically similar but have some differences based on different program objectives. Agriculture reguires that the States establish priorities for locations needing WIC and that these priorities be based on health indicators, such as low birth weight and infant mortality rates, low income, and other factors concerning the health needs of the target population.

Although some HEW programs are geared toward providing services to the same population that would be eligible for the WIC program, they are also designed to serve other segments of the population. For example, the community health center services cover a wide range of needs including family planning, dental care, obstetric and pediatric care, geriatrics, and other needs. Therefore, when selecting areas for its programs, HEW considers factors other than those affecting WIC participants such as the number of elderly in an area and population-to-physician ratios.

Because of the different factors involved, the areas HEW selects to receive its funds for expanding health services may not always be those locations that Agriculture determines to need WIC programs. This sometimes creates a problem in establishing local WIC programs. For example, officials in New York and Illinois have told us that they are experiencing difficulties in expanding the WIC program to needy areas because these areas do not have adequate health resources available to low-income people. Placing a WIC program in these areas might be contrary to the intent of WIC's authorizing legislation because the program might not be able to operate as an adjunct to good health care. Where possible, the WIC program should be expanded into areas with existing State and local or private health facilities, including those operating HEW-funded health programs.

Coordination efforts between Agriculture and HEW are improving

Past coordination efforts between HEW and Agriculture officials were limited and ineffective. An HEW official described the coordination as "at best time-consuming and less than productive." However, Agriculture and HEW officials have taken several steps to coordinate their programs. These include:

--Panel discussions between Agriculture and HEW officials regarding implementation of new program legislation, policies, and regulations.

--Meetings with Agriculture and HEW staff to discuss better ways of coordinating both Departments' efforts in expanding the WIC program and HEW's health care efforts. In this regard, both Departments have reviewed lists of clinics receiving HEW funds to discern which clinics do not operate WIC programs and why. Agriculture officials told us that both Departments intend to coordinate efforts in placing the program where it is most needed.

Hopefully, these recent steps to improve coordination will continue and expand. However, in order for this coordination to succeed and for the program to function as the Congress intended, officials from both Departments must find a way to reconcile their differing views on what areas should have priority in receiving WIC and HEW-funded health services. Agriculture and HEW officials must insure, for each area being considered by the State for a WIC program, that a program is truly needed and whether WIC will be able to effectively function as an adjunct to good health care.

HEALTH SERVICE AVAILABILITY LIKELY TO BE A CONTINUING PROBLEM

Health care accessibility for WIC participants could continue to be difficult without additional Federal, State, local and private health care sector efforts to provide the needed services. WIC is scheduled to more than double in size under the Child Nutrition Amendments of 1978, while a similar increase in HEW funds for local clinics having good potential as WIC agencies is not currently planned. Improved coordination and other efforts may not be sufficient to ensure that health care will be available to all WIC participants if substantially more of these services are needed to enable a larger WIC program to operate as an adjunct to good health care.

As discussed in chapter 1, $250 million was authorized for WIC for each of fiscal years 1976 through 1978. Using the 1978 authorization and about $120 million carried over from previous fiscal years, the program operated at about a $370-million-a-year level in fiscal year 1978. The Child Nutrition Amendments of 1978 (92 Stat. 3616) authorizes $550 million for WIC for fiscal year 1979, $800 million for 1980, $900 million for 1981, and $950 million for 1982. Even allowing for cost increases due to inflation, increases of this magnitude, if fully funded, will result in substantially more WIC participants and a corresponding need for more health services if WIC is to operate as an adjunct to good health care.

Although there might be some opportunities for expanding WIC into areas with HEW-funded clinics, such opportunities would not be the total answer. HEW recently surveyed 518 clinics receiving its funds and found that 244 of them were not associated with WIC, either as sponsoring agencies or in any other respect. This might seem to indicate that the program could easily expand into the areas served by clinics not now associated with WIC, but in most instances this is not the case. Of the 244 clinics, 156 were in areas where other agencies already were operating WIC programs, 40 were trying to become associated with WIC, and 10 did not have the capacity to handle WIC programs. The possibility that the remaining 38 clinics have potential for WIC sponsorship is uncertain.

Obtaining needed health services for WIC participants from sources other than HEW-funded clinics could also be a problem in some areas. Some State and local health agencies do not have sufficient resources to provide health care to all those in need. As discussed previously, obtaining medical services for WIC participants from private sources can be difficult because they frequently rely on medicaid to pay for the services and many physicians are reluctant to accept medicaid patients. In addition, HEW data shows over 7,200 areas, with a combined population of about 45 million people, that are classified as medically underserved; that is, they have shortages of personal health services. These shortages and the problems associated with paying for WIC participants' health services can make it more difficult to expand WIC as provided in the Child Nutrition Amendments of 1978.

CONCLUSIONS

To help WIC achieve its objective of operating as an adjunct to good health care, improvements are needed in WIC's administration, its coordination with HEW health care programs, and its authorizing legislation. Although State and local governments in cooperation with the Federal Government have the primary responsibility for providing health care to members of low-income families, better coordination between HEW and Agriculture could improve the availability of health care to WIC participants. Coordination efforts seem to be improving but continuation of effective coordination efforts will be critical as WIC expands. Also, the Service needs to make specific efforts to learn more about State activities in administering WIC to make sure the program is operating the way it was intended to operate.

Despite efforts to make health services available to WIC participants, it might be difficult to operate WIC as an

adjunct to good health care if the availability of the types of health services WIC participants need does not keep pace with WIC expansion. Solutions to WIC's problems in achieving its health care objectives will involve tough decisions, but such decisions will have to be made if WIC is to avoid becoming simply a food assistance program.

RECOMMENDATIONS TO THE CONGRESS

To strengthen WIC's health care aspects and have WIC operate specifically and effectively as an adjunct to good health care for women, infants, and children of low-income families considered to be at nutritional risk, we recommend that the Congress revise WIC's authorizing legislation to clearly require that participants receive needed health services where such services are available, accessible, and acceptable--with possible exceptions based on participants' religious beliefs. Without health services, WIC would be simply a food distribution program--a result not intended by the Congress in enacting this program.

To accomplish this recommendation, section 17 of the Child Nutrition Act of 1966 (42 U.S.C. 1786) should be amended as follows. A new paragraph (4) should be added to the end of subsection (d), as follows.

> "(4) Where health services are available, accessible, and acceptable, participants must, as a condition of receiving supplemental food and other program benefits under this section, receive appropriate health services from the local agency or another acceptable source, provided, however, that any participant who objects to receiving health services based on stated religious beliefs shall not be precluded from receiving benefits under this section."

At present, existing program regulations which require that health services be available in an area before a WIC program is approved are not being strictly observed. As part of the oversight of this program, the Congress should monitor the Department of Agriculture's actions on our recommendation that the Department work with the States and local agencies and with the Department of Health, Education, and Welfare to provide needed services in those present and planned program areas where adequate health services are not available, accessible, and acceptable. A problem that must be addressed by the Congress is whether the benefits of the food supplement part of the program alone warrant its expansion to areas where needed health services cannot be delivered.

RECOMMENDATIONS TO THE SECRETARY OF AGRICULTURE

To ensure that the WIC program genuinely operates as an adjunct to good health care, as mandated by the authorizing legislation, we recommend that the Secretary of Agriculture take the following steps, regardless of whether the legislation is revised as recommended above.

--Require that States and other authorized grantees take more effective measures to assure that health services will be available to all potential WIC participants before approving new local programs or major program expansions. Such measures should include a requirement that specified documentation from sponsor applicants show detailed information about public and private health service capacity in the target area, including firm agreements with private doctors and other health providers that would assure needed care for low-income WIC participants.

--Insure that all States, especially Illinois and Washington, are properly interpreting Federal program regulations as requiring that needed health services, including prenatal and pediatric care, be made available to WIC participants.

--Make certain that Department reviewers keep close watch on State efforts to arrange for appropriate health services for WIC program participants and to insure that such services are actually available to participants as needed.

--Where adequate health services are not available, accessible, and acceptable in present and planned WIC program areas, direct that the Department work with the States and local public and private agencies, and with HEW, to provide the needed services.

--Arrange for Agriculture and HEW to jointly determine whether sufficient acceptable health services will be available for an expanded WIC program to operate as an adjunct to good health care. If problems appear likely in this regard, the Executive Branch should consult with the Congress and, within the framework of the Government's overall budget policy, consider various alternative solutions geared to maximizing the effectiveness of available health resources.

AGENCY COMMENTS AND OUR EVALUATION

The Department of Agriculture did not agree with our recommendation to require participants to receive health services as a condition of receiving WIC foods. Department representatives said that participants should be free to receive health services from their family physician if they want and should not be forced to receive health services if doing so is contrary to their religious beliefs. Our recommendation and the language we propose would permit participants to receive health services from any source licensed by State or local authorities and would permit the requirement to be waived if a participant objected based on religious beliefs.

Although they believe that health services are important, Department representatives noted that recently completed studies show significant benefits from receiving WIC supplemental food alone--even without health services. Because of these benefits, they believe that the supplemental food should not be denied to participants because they do not receive health services.

The Department's rationale seems inconsistent with WIC's basic design and objective of operating as an adjunct to health care. If this basic objective is to be retained and achieved, as we believe the Congress intended, the WIC program needs to be operated as a comprehensive program in which eligible participants systematically receive a package of benefits that includes health services as well as other program benefits. To this end, we believe that receiving health services should be made a program requirement.

HEW officials believe that the WIC program must have a close tie-in to health care and that this and other matters discussed throughout the report are significant program issues that need attention and effective coordination between Agriculture and HEW.

CHAPTER 3

PROBLEMS WITH NUTRITIONAL RISK ASSESSMENTS AND FOOD PACKAGES

For the WIC program to function effectively as an adjunct to good health care, it is essential that the nutritional needs of each applicant be determined through a medical or nutritional assessment by a competent professional authority and that, based on such assessment, a food package be prescribed to meet the individual's identified nutritional needs. Although this is required by Federal program regulations, some local clinics we visited were not making the needed assessments. Further, the use of different criteria by different States as as to what constitutes nutritional risk results in considerable uncertainties and inconsistencies as to the nutritional status and eligibility of program participants.

With some exceptions, the clinics were making little or no attempt to prescribe individual food packages, based on feedback from professional assessments, that would provide the kinds and quantities of food needed to satisfy each participant's nutritional needs. In a few cases, the food packages distributed could have aggravated a participant's health condition. WIC projects generally had little incentive or inclination to tailor food packages to specific needs. In some cases, food prescriptions could not be made because required nutritional assessments had not been made; in other cases, WIC agency staff simply were not receiving needed professional advice that would enable them to tailor a food package to a participant's health condition and nutritional needs. Also, there was some feeling among some local program personnel that participants are poor and need the maximum quantity of food allowable under the program, regardless of their nutritional/health status.

The failure of WIC clinics to prescribe specific food packages could result in the food packages being perceived as the end objective of the WIC program--without specific relation to maintaining the health of participants identified as being at nutritional risk.

SOME PROBLEMS IN OBTAINING PROPER ASSESSMENTS OF APPLICANTS' NUTRITIONAL/HEALTH STATUS

The WIC program is generally considered as a major weapon in the fight against the nutritional risks often borne by pregnant or lactating women and by infants and children. Applicants must be determined to be at nutritional risk due

to both low income and nutritional need, and a competent professional authority (physician, nurse, or other health official) must determine, through a medical or nutritional assessment, whether the applicant meets the nutritional need requirements established by State and local health officials in each State.

In most of the clinics we visited, nutritional assessments generally were being made by professionals as required. Such assessments were made by either WIC clinic staff, by other clinics, or by hospitals or private physicians. The assessments usually included some physical examination and measurements, blood tests, and interviews. However, the results of assessments made by professionals outside the WIC agency generally were not routinely being made available to WIC clinic staff for use in the program. Apparently, WIC personnel did not tell the outside professionals to submit the assessment results or such instructions if given, were not followed.

In Illinois we reviewed 25 active WIC cases (15 women and 10 infants or children) at each of five WIC clinics to identify the most common reasons for nutritional need certification. The most common reasons for women were:

(1) Anemia
(2) Inadequate nutritional pattern
(3) Obesity
(4) Short periods between pregnancies
(5) Abnormal pattern of pregnancy weight gain

The most common reasons for infants and children were:

(1) Inadequate nutritional pattern
(2) Mother on WIC during pregnancy
(3) Other (born of high-risk pregnancy, mother anemic, deficient growth pattern, etc...)
(4) Premature birth or low birth weight
(5) Anemia

In most cases, multiple reasons were shown. For women, the average was three; for infants and children, the average was two.

In 6 of the 20 clinics we visited, the prescribed assessments were not always made and used as the basis for a health maintenance program for each WIC participant. One of the WIC clinics in Washington had no professional staff to assess the nutritional needs of prospective participants. About 240 people were admitted to the

program at this clinic without any nutritional assessments. We were told (in August 1978) that the clinic's medical staff had resigned in March 1978 and that the WIC program would be transferred to a health facility that could provide needed professional services. Also, the records of 51 participants we checked at three clinics in Washington indicated that 5 participants did not meet the State's nutritional risk criteria and, therefore, were ineligible for the program.

WIC program files for 125 participants selected from five clinics in Washington showed that the clinics had not made 84 nutritional assessments and/or reassessments required for program certification--51 of these failures related to 25 participants at one clinic. Overall, only about 60 percent of the initial nutritional assessments required had been made.

Of 25 participants whose files we checked at a local clinic in Louisiana, the clinic staff had improperly certified 5 participants as eligible for program benefits on the basis of low income alone. No professional assessments were made to determine the applicants' nutritional health status.

NEED TO ESTABLISH AND USE ACCEPTABLE STANDARD CRITERIA FOR ASSESSING NUTRITIONAL RISK

Federal program regulations have set broad guidelines for identifying applicants at nutritional risk and have permitted State health officials to establish their own specific nutritional assessment criteria. Because medical judgments vary among professionals, significant differences existed in the criteria for determining nutritional risk in the four States where we made our review--both from an income standpoint and from a nutritional/health standpoint. Such differences have given rise to considerable uncertainty among competent professionals as to what actually constitutes nutritional risk and consequent eligibility for WIC program benefits. Also, an applicant considered to be at nutritional risk (and eligible for the program) in one State could be considered not at nutritional risk (and therefore ineligible) in another State--depending on the criteria applied.

Basic Federal program guidelines for determining nutritional risk include the following.

INCOME

Income standard to be provided or approved by the State agency. If local agency offers free or reduced cost health care to all, no income standard is required for WIC program participation.

NUTRITIONAL NEED

Pregnant, postpartum, and breastfeeding women	Infant or child
anemia	anemia
abnormal pattern of growth such as underweight or obesity	abnormal pattern of growth such as underweight, obesity, or stunting; including for infants, a birth weight of 2500 grams or less
inadequate nutritional pattern (poor dietary habits)	inadequate nutritional pattern
high risk pregnancy or a history of premature births, miscarriages, or high risk pregnancies	status as infant (up to 6 months of age) of a mother who was a WIC participant during pregnancy

Each of the four States in our review have followed the above guidelines but, as shown in the comparative listing in appendix III, major differences exist from State to State. For example, blood test levels used to identify anemia in women, infants, and children were as follows.

	Hemoglobin			Hematocrit		
	Women	Infants	Children	Women	Infants	Children
	(gm per 100 ml)			(percent)		
Illinois	13	11	11	38	34	34
Louisiana	11	11	11	34	34	34
New York	12	12	12	37	37	37
Seneca Nation Indian reservation a/	12	11.6	11.6	37	34	34
Washington	11.5	10	11	33	31	34

a/The Seneca Nation Indian reservation in New York is treated in the same manner as a State agency for purposes of program administration.

By using different blood test standards, each State in effect makes its own determination as to what constitutes anemia for purposes of program eligibility. A pregnant or postpartum woman in Washington, for example, would have to have a hematocrit level of 33 or less, or a hemoglobin level of 11.5 or less, to be considered in nutritional need because of anemia. If the same woman lived in New York State, her hematocrit level would only need to be 37 or less, or her hemoglobin level 12 or less, to be considered in nutritional need and therefore eligible for WIC (provided the State's income requirement is met).

There are numerous other differences in State criteria for determining nutritional risk and, consequently, program eligibility. Some of the criteria factors deal with actual nutritional deficiencies or health problems; some are prevention oriented and deal with the likelihood or possibility of a problem arising. Some States (such as New York) have a relatively broad range of factors, including psychological factors. Others (such as Louisiana and the Seneca Nation) have less and generally more restrictive factors.

With such variations in certifying criteria, program eligibility could become more a condition of geographic residence than of actual health. Thus, some applicants considered ineligible in one State could have a more severe health condition, for example, than an eligible participant in another State. This does not seem equitable.

A further complication is that some medical experts do not agree that the readings specified in various State criteria signify the problem condition indicated by the criteria. For example, we were told by our medical consultant that a hemoglobin level of 11 grams per 100 milliliters is a strong indication of an iron deficiency, whereas a level of 12 grams per 100 milliliters might not indicate an iron deficiency and would require more testing to make a positive determination. Also, we were told that a hematocrit level of 34 percent would have the same implication as a hemoglobin level of 11 grams per 100 milliliters, while a hematocrit level of 37 percent would equate to a hemoglobin level of 12 grams per 100 milliliters.

These views are supported by the standards for identifying nutritional risk in pregnant women published by the American College of Obstetricians and Gynecologists. These standards include, among others:

> Hemoglobin levels less than 11 are considered to be low readings and patients are likely to be at nutritional risk. A reading less than 10 is considered to be a deficient reading and indicative of nutritional risk.
>
> Hematocrit levels less than 33 are considered to be low readings and patients are likely to be at nutritional risk. A reading less than 30 is considered to be a deficient reading and indicative of nutritional risk.

The World Health Organization has established the following anemia levels, which support the medical expert views expressed above.

	Hemoglobin	Hematocrit
Infants	below 11	below 34
Children	below 11	below 34

We asked professional staff at the local WIC clinics we visited to review the nutritional need assessments in selected WIC cases to ascertain whether the conditions documented in the case files placed the individual at nutritional risk, according to the above criteria, and whether the criteria for assessing nutritional risk are likely to be applied consistently.

Of 341 cases where files were made available to us, there were 45 instances in which clinic professional staff felt that application of State criteria did not demonstrate nutritional need. These instances generally involved criteria levels for demonstrating anemia and inadequate growth patterns. Aside from one case where a participant was erroneously certified for anemia, there were 15 cases in which readings for anemia fell within the State certifying criteria but did not, in the opinion of clinic professional staff reviewing these cases, demonstrate anemia.

For example, a child with a hematocrit level of 36 percent was certified for anemia in a local WIC program in New York, but was not considered to be anemic by professional staff who reviewed the case for us even though a 36 percent hematocrit level met the State's certifying criteria. A woman with a hemoglobin level of 12.4 grams per 100 milliliters and a hematocrit level of 37 percent, was certified for anemia in an Illinois program. While both of these readings met the State's certifying criteria of 13 grams per 100 milliliters or less for hemoglobin and 38 percent or less for hematocrit, the woman was not considered to be anemic in the judgment of the professional staff who reviewed the case.

It should be noted that in each of these cases, the participants would not have been considered eligible for the WIC program in Washington or Louisiana where the certifying levels for anemia are:

	Washington		Louisiana	
	Hemoglobin	Hematocrit	Hemoglobin	Hematocrit
Children	11	34	11	34
Women	11.5	33	11	34

Twenty-nine of the 341 cases were certified for abnormal growth patterns; however, staff professionals examined the growth charts in the case medical records and expressed their professional opinions that available evidence did not show an abnormal growth condition that would place the participant at nutritional risk. As in the case of anemia, this placed the opinions of professional staff in disagreement with State certifying criteria for abnormal growth patterns.

For example, in a case in Illinois, an infant was certified as being underweight at 6 months of age because the infant weighed less than the standard of 16 pounds.

Professional staff who reviewed this case felt that the infant's actual weight of 14 pounds, 13-1/2 ounces, did not evidence an abnormal growth pattern and consequent nutritional risk.

Some staff professionals expressed concern about the reliability of the method used to determine applicants' diet adequacy and, therefore, nutritional need. Applicants are asked to recall for WIC personnel all of the food they consumed in the previous 24 hours. One nutritionist said that she suspects that some WIC women altered their 24-hour recall to please the staff member recording the data. She also expressed the belief that some women could not remember all of the food they and their children had eaten in the past 24 hours.

We recognize that the examples given above are not clear-cut, and that differences of opinion can arise in matters relating to an individual's nutritional/health status. It is not our intention to pit the views of one group of experts against another, but we do want to highlight the need to afford each prospective WIC participant equitable consideration for program eligibility, provide consistency in nutritional risk assessments, and minimize differences and uncertainties among certifying professional staffs as to who is at nutritional risk. We believe that a good way to do this is to have recognized professional groups such as the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics, work together, in cooperation with Federal authorities, to promulgate a uniform criteria for States to follow in making nutritional risk assessments.

The American College of Obstetricians and Gynecologists has published standards for identifying nutritional risk in pregnant women. It would seem logical and appropriate to use these as the basis for uniform, nationwide WIC program standards. The American College of Obstetricians and Gynecologists standards, for example, consider pregnant women to be at nutritional risk in the following situations:

--Fifteen years old or less.

--Three or more pregnancies within the last 2 years.

--Prepregnancy weight at first visit of less than 85 percent, or more than 120 percent, of standard weight.

--Hemoglobin level less than 11 considered to be a low reading with patient likely to be at nutritional risk; a level less than 10 is considered to be a deficient reading and indicative of nutritional risk.

--Hematocrit level less than 33 considered to be a low reading with patient likely to be at nutritional risk; a level less than 30 is considered to be a deficient reading and indicative of nutritional risk.

Growth and development standards to identify the overweight, the underweight, the overgainer, the undergainer, and the erratic gainer are also available from HEW and professional organizations.

We see these as some possibilities that the Department of Agriculture should consider in establishing uniform criteria for States to follow in making more uniform, consistent, and acceptable nutritional risk assessments for the WIC program. Such criteria could also help eliminate unequal treatment of individuals with similar problems or potentials, and help more closely align program resources with the actual needs of those for whose benefit the program was established.

Regulations recently proposed by the Food and Nutrition Service to implement the Child Nutrition Amendments of 1978 contain criteria for what constitutes nutritional risk but would still allow each State agency to establish additional criteria. Thus, there could still be significant differences in the criteria used for determining nutritional risk. The proposed Federal guidelines for determining nutritional risk include the following.

Pregnant, postpartum, and breastfeeding women	Infant or child
Detrimental or abnormal nutritional conditions, such as anemia, abnormal weight gain, and loss of weight.	Detrimental or abnormal nutritional conditions, such anemia, phenylketonuria, abnormal growth pattern including obesity, stunting, or a birth weight of 2,500 grams or less.
Other documented nutritional related medical conditions, such as toxemia, diabetes, vitamin and mineral deficiencies, lead poisoning, hypoglycemia, alcoholism, and drug addiction.	Other documented nutritionally related medical conditions, such as diabetes, hypoglycemia, vitamin and mineral deficiencies, and failure to thrive.
Dietary deficiencies that impair or endanger health.	Dietary deficiencies that impair or endanger health.
Conditions which predispose persons to inadequate nutritional patterns or nutritionally related medical conditions, such as history of alcoholism and drug abuse or chronic infections, mental retardation, and pregnancy over 35 years of age, or conception prior to 16 months postpartum.	Conditions which predispose persons to inadequate nutritional patterns or nutritionally related medical conditions, such as chronic infections, intestinal parasites, pyloric stenosis, a history of sibling failure to thrive or infant of an alcoholic, mentally retarded, or drug addicted mother, and physical anomalies which preclude proper ingestion of food.
	Status as an infant (up to six months of age) of a mother who either was a participant during pregnancy or was at nutritional risk during pregnancy.

Although the proposed additional criteria for nutritional risk are more specific in some respects than the criteria now used, they could still be subject to differing interpretations by State agencies. For example, the proposed regulations do not set standards for hematocrit and/or

hemoglobin levels. Therefore, a person eligible for program participation in one State could still be ineligible in another, as shown earlier.

The proposed regulations also provide criteria for qualification as a competent professional authority for making nutritional risk determinations. They also provide for the levying of fiscal sanctions against the State agency based upon a statistically valid sample of program records by the Service. These sanctions could be applied in the event of improper certifications for program eligibility.

LACK OF SYSTEMATIC APPROACH FOR TAILORING FOOD PACKAGES TO SATISFY INDIVIDUAL PARTICIPANT'S NEEDS

Generally, little effort was being made in the four States we visited to prescribe specific types and quantities of supplemental food that would satisfy the nutritional needs identified in professional assessments of an individual's nutritional/health condition. This is contrary to the program's legislation and the requirements established by the Department.

In a discussion printed in the Federal Register preceding final revised regulations for the WIC program, the Department explained its views on food package tailoring.

> "Many commenters opposed the requirement that the competent professional authority tailor the food package to the individual's nutritional needs because they considered the process time-consuming and an administrative burden. However, this requirement corresponds with the intent of the WIC Program, which is targeted to specific individuals determined to be in nutritional need. In addition, the Department feels it is not cost effective to provide food in greater quantities than indicated in the nutritional need determination, or to provide more food than an individual can consume. Additionally, the local agency can use the funds saved through eliminating the excess food to serve more persons. Therefore, the requirement remains."

We believe the Department's views are right on target. Unfortunately, the quantity of food being given to individual participants in most cases was at standard maximum levels, without any attempts to tailor the kinds and amounts of food to meet individual nutritional needs. There were some exceptions which are discussed later in this section.

Food package contents

Prior to recent amendments, the program's legislation required that the supplemental food package contain nutrients known to be lacking in the program participants' diet, particularly high quality protein, iron, calcium, and vitamins A and C. In line with this, Federal regulations set the following maximum quantities of foods to be distributed monthly to infants; children; pregnant, postpartum, or breastfeeding women; and children with special dietary needs.

Infants	Women and children
Iron-fortified formula; 403 fluid ounces	Milk and/or cheese; 28 quarts of milk or 9.3 pounds of cheese
Infant cereal; 24 ounces	Cereal; 36 ounces
Fruit juices; 92 fluid ounces	Fruit juices; 276 fluid ounces
	Eggs; 2.5 dozen

Program legislation and regulations provide for the contents of the food packages to be flexible, taking into account medical and nutritional objectives and cultural eating patterns for individual participants.

Some clinic nutritionists commented that the choice of WIC foods is too restrictive and that food selection should be increased. One said that food monotony is a major problem with the WIC package. She said that she advises participants to eat fruits and vegetables but that few do because such foods are expensive.

We have also noted in a recent news article that there have been some complaints that infant formulas need not always be fortified with iron and that the more expensive ready-mix formulas should not be preferred over the concentrated mixes that mothers can prepare themselves. Greater flexibility in WIC food selection was urged.

Most WIC participants we talked with were generally satisfied with the types of food available. Comments ranged as follows.

--The food the program provides is nutritious and is important to them and their children's diet.

--The food package contains items which probably would not normally be part of their basic diet.

--They could not otherwise afford to buy the quantities of certain food in the package.

--The variety and quantity of WIC foods should be expanded to include fresh fruits and vegetables.

--Eliminate powdered milk and cheese from the package.

--Change the choice of cereal.

The recently enacted child nutrition amendments do not specify which nutrients must be provided in the supplemental food. The legislation authorizes the Secretary of Agriculture to provide nutrients that nutritional research determines are lacking in the diets of the program population. In commenting on this provision in the Federal Register (44 F.R. 2120, January 9, 1979) the Department stated that it is reviewing the pertinent literature on this matter to identify the necessary nutrients and consider the various foods which supply the nutrients. The Department is also considering developing several additional food packages to provide foods which are more appropriate for each category of participants. Additionally, the new law states that the levels of fat, sugar, and salt must be appropriate, to the degree possible, for the program participants, but does not specify what constitutes "appropriate."

Service officials told us that needed information is not available to enable them to establish appropriate levels of fat, sugar, and salt for program participants. Additional research will need to be done before such levels can be determined and established.

Food packages generally not tailored to individual need

The kind of tailoring we noted most often involved prescribing a substitute formula where it was known that an infant was allergic to a regular milk formula. For example, a WIC infant was given a soybean formula when it was determined the infant had an oversupply of milk in his diet. Some clinics gave low-fat milk or other substitution food to obese participants. For example, a child considered to be overweight because of too much milk received a modified food package which reduced the monthly allotment of milk by nine quarts and substituted three pounds of cheese. These types of substitutions represent one kind of tailoring that sometimes result from identified nutritional problems. We did not find much of this occurring. For example, in one State

where about 30,000 infants and children received WIC food vouchers, there were 12 instances in one month where some food tailoring was done because an infant or child needed special powdered formula, was over 3 months of age and being breastfed or had a documented allergy to some WIC food package item.

We also found some deviations from standard food packages which do not represent bonafide food package tailoring as envisioned in program regulations. For example, at some clinics, participants could receive less than the total package--if they requested less. Also, some substitutions were made to accommodate personal preferences--especially when the participant was not finishing a particular food item as fast as it was being provided.

Health and medical professionals with whom we discussed participant medical information cited cases where, in their opinion, food package tailoring ought to have occurred and did not. Examples included the following.

--A child was certified for anemia and found to be receiving an oversupply of milk in his diet--a possible contributing factor to the child's anemia. Yet, this child received a standard amount of milk through the maximum WIC food package.

--A child diagnosed as having milk anemia was given the standard food package instead of one which excluded milk.

--A 17-year old girl, 5 feet 2 inches tall and weighing 216 pounds in her second trimester of pregnancy, was given the standard full food package.

--A pregnant woman who had an abnormal weight gain (16 pounds in 2 months of pregnancy) was routinely given the full standard food package.

--A pregnant woman with high blood pressure and weighing over 300 pounds (about 100 percent overweight) received the full standard food package.

Although Federal regulations currently do not permit it, medical people told us that, in some cases, participants with insufficient weight gain during pregnancy could benefit from receiving more than the maximum food package allowable. We believe that effectively addressing individual nutritional needs will sometimes require prescribing less than the maximum food package presently authorized; in other cases, it could require more than the currently approved maximum package.

Some of the WIC clinics we visited did not have staff with the necessary training or experience to properly tailor food packages for program participants. In some cases, clerical staff dispensed food packages. In most cases, however, qualified staff was available but was not always involved in dispensing the food or food vouchers. Some program personnel were not too concerned about tailoring food packages to individuals' needs because they felt that program participants were from poor economic backgrounds, needed the maximum quantity of food available from a standard package, and could only benefit from the food provided.

Even with adequate staff capability for tailoring food packages, systematic procedures are needed for directly relating a participant's nutritional food package to that participant's health status and needs. This generally was lacking at the clinics we visited. In some cases, current information on participants' medical status was unavailable for reference, or information from private medical sources was not made available to WIC program staff. In other cases, information from (or based on) medical records could have easily been made available, but was just not routinely provided to the local programs' food staffs.

Views differ on the importance and necessity of tailoring WIC food packages. Some professionals said that it is important to deal with the individual's specific needs, while others believe it is rare that anything in the WIC food package, even at its maximum level, could harm the individual participant.

One WIC official said that the present basic food packages do not address the individual nutritional needs of each participant and that it is not practical to identify exact nutritional deficiencies at the health units. This official said that the basic WIC food package was not intended to meet each participant's individual nutritional needs, but was designed to eliminate common nutritional deficiencies noted in a 1968-69 survey 1/ of nutritional deficiencies in 10 States.

Some clinic nutritionists expressed the view that a physician should be consulted for each participant. One believed that physicians should give each WIC participant

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1/U.S. Department of Health, Education, and Welfare. "Ten-State Nutrition Survey, 1968-1970." Vols. 1-v and Highlights, DHEW Publication No. (HSM) 72-8130 - 72-8134, 1972.

a complete physical examination and approve a dietary plan that should be adhered to. She also believed that a serious deficiency exists in the WIC program because physicians are not systematically consulted in establishing WIC participants' nutritional deficiencies and dietary plans.

A WIC official and nutritionists at one clinic expressed the belief that advising participants on food preparation and their dietary habits constituted food package tailoring. They cited the examples of a WIC participant with high blood pressure being advised to reduce the consumption of certain foods high in sodium and obese participants being advised to restrict their sugar intake.

One nutritionist said that food tailoring would be effective only if the WIC participant is sold on the concept of food tailoring. According to the nutritionist, WIC participants must accept nutritional counseling covering their total diet in order to make food package tailoring effective.

We agree that nutritional counseling is important. Overall, however, we believe that the basic question should be whether WIC food packages are used as bonafide food supplements aimed at enhancing participants' nutritional/health status.

In one State, we asked physicians for their opinions regarding the effect of WIC foods on program participants. Based on reviews of participants' medical records--primarily changes in hemoglobin/hematocrit readings and growth patterns--the physicians made the following comments.

Comment	Women		Infants and Children		Total	
	Number	Percent	Number	Percent	Number	Percent
Foods improved participant's nutritional condition	10	32	8	26	18	29
No apparent changes noted	3	10	6	19	9	14
Insufficient data to evaluate	9	29	2	7	11	18
Participant not considered to have nutritional deficiency	9	29	15	48	24	39
Total	31	100	31	100	62	100

The opinions offered indicate that some participants improved their nutritional/health status and that, hopefully, WIC program benefits played a role in this. The opinions also indicate that there is room to improve program results through more effective use of the food supplements provided participants.

Disincentive to food package tailoring

State and local agency officials with whom we discussed the program indicated that, in the past, there has been little incentive to tailor food packages. Program administrative cost reimbursement has been based on a percentage of food cost and it has been more advantageous to distribute the maximum food package allowable to generate the maximum administrative reimbursement--the higher the food costs, the higher the administrative reimbursement.

The 1978 child nutrition amendments provide for removing this disincentive to food package tailoring. The new law requires the Secretary of Agriculture to develop and implement a new formula for allocating administrative funds to States and new guidelines for States to use in developing

standards for allocating administrative funds to local WIC agencies. The Service's new formula for distributing administrative funds to States under the new law does not consider food costs and therefore does not contain a disincentive to food package tailoring. However, the Service's proposed regulations regarding State formulas for distributing administrative funds to local agencies do not prohibit States from including food costs in their formulas. To preclude disincentives to food package tailoring at the local level--where its impact would be greatest--we believe Service regulations should specifically prohibit States from considering food costs in distributing administrative funds to local agencies.

CONCLUSIONS

To have the WIC program function effectively as an adjunct to good health care, we believe that WIC participants need to receive good nutritional/health assessments and reassessments by competent professionals in accordance with uniform, generally accepted criteria that are consistently applied. Thus, the necessary first step is to identify real nutritional needs and problems. The second and equally important step is to ensure that the participant's identified needs and problems are addressed, to the maximum extent possible, through individual prescriptions of supplemental food packages. Without a specific relationship between a participant's health status and the food package the participant receives, the program will become simply a food distribution program--an end not envisioned or intended by the authorizing legislation and Federal regulations.

RECOMMENDATIONS TO THE SECRETARY OF AGRICULTURE

We recommend that the Secretary of Agriculture:

--Work with HEW and recognized professional groups, such as the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics to develop uniform standards and criteria for determining what constitutes bonafide nutritional/health risk for the different classes of WIC program participants (women, infants, and children). Such criteria should be uniformly applied across the board to ensure equitable and consistent treatment of the program's target population.

--Require that nutritional risk assessments be made at specified intervals by competent professionals in

accordance with established uniform criteria, and that the results of all such assessments, including assessments by outside providers, be made available to clinic staff for program purposes.

--Preclude disincentives to food package tailoring by specifically prohibiting States from considering food costs in distributing administrative funds to local agencies.

--Require that individual food packages be prescribed to provide the kinds and quantities of foods needed to meet the specific nutritional needs of each recipient. Such prescriptions should be based on systematic feedback from nutritional risk assessments made by competent professionals and should specifically provide that greater or lesser amounts of food (than contained in the current standard package) be authorized and prescribed in accordance with case-by-case professional determinations of need.

--Make certain that the Department's regional offices and its internal audit staff systematically evaluate and report on State management controls over (1) the nature, extent, and frequency of the nutritional risk assessments of program participants and (2) the basis for, and extent of, food package prescriptions made to enable individual participant's nutritional/health needs to be met.

To enable Agriculture to effectively implement the legislative provision in the newly enacted Child Nutrition Amendments which requires that WIC program regulations specify, to the degree possible, the levels of fat, sugar, and salt appropriate for WIC participants, we recommend that the Secretary direct that research be started to obtain the needed information.

AGENCY COMMENTS AND OUR EVALUATION

The Department of Agriculture did not agree with our recommendation that uniform standards for judging nutritional risk be developed and applied across the board. Department officials believed that each State should continue to establish its own standards for nutritional risk.

We believe that in a nationwide Federal program such as WIC, care must be taken so that applicants in different States are treated the same to the maximum extent practicable. Current standards for judging nutritional risk allow applicants with identical nutritional conditions to be treated differently in different States. Accordingly, we continue to believe that uniform standards are needed.

The Department believes that we have misconceptions regarding the meaning of the term food "tailoring" and its use in the WIC program. We have tried to base our interpretation on what we believe to be the intent of the WIC program. As noted earlier in this chapter, program legislation and regulations provide for the contents of the food package to be flexible, taking into account medical and nutritional objectives and cultural eating patterns for individual participants. We believe our views on food package tailoring are consistent with this and with an earlier Department discussion (see p. 33) of the need to have a competent professional authority tailor the WIC food package to an individual's nutritional needs.

CHAPTER 4

MORE EMPHASIS AND COORDINATION NEEDED IN NUTRITION EDUCATION

The nutrition education component of the WIC program has not received the priority that it deserves and that the Congress intended it to have. The Food and Nutrition Service has not provided the States sufficiently specific guidance on what is required in nutrition education and has not followed up to make sure nutrition education is included as an integral part of local WIC programs. Overall, the Service has not given nutrition education enough emphasis.

State involvement in guiding and coordinating the nutrition education efforts of local WIC agencies varies considerably. This was reflected in the widely differing nutritional program components we observed at local clinics. Some local programs had nutrition education conponents that seemed well thought out; others offered little or no nutrition education. One local program we reviewed was assessing the extent to which individual participants seemed to be benefiting from the nutrition education they received. None of them, however, were regularly evaluating the overall effectiveness of their nutrition education activities in teaching participants how to improve their diets and nutritional status and in getting them to use WIC's supplemental foods wisely.

The Congress made nutrition education a part of the WIC program because it wanted participants to be taught what foods were most nutritious and how to include these foods in their daily diets. It hoped participants would continue to use this knowledge after leaving the program. This intent was reaffirmed and strengthened in the recently enacted amendments to the Child Nutrition Act which require the Department of Agriculture to take steps to improve WIC's nutrition education.

NEED FOR BETTER GUIDANCE ON NUTRITION EDUCATION AT THE FEDERAL AND STATE LEVEL

The quality of WIC's nutrition education component varied widely among States and local WIC agencies partly because the Service had not provided the States with enough guidance on how to structure and evaluate such a program component.

Service officials felt that most State agencies had the capability to structure their own programs and would require very little assistance in setting up a WIC nutrition education component. As a result, most States and local WIC agencies we visited viewed the importance of nutrition education differently and established differing requirements for implementation.

Federal guidance

The Service contends that State health agencies, which are WIC grantees, usually have established policies and guidance materials to use in planning and implementing nutrition services in health care programs. These policies and guidance materials are reviewed and approved by medical advisory groups as well as by State health agency officials. The Service assumes that, since WIC programs are supposed to be developed as an adjunct to these health care programs, nutrition education will be an integral component of WIC participants' health care. However, as discussed later in this chapter, some State and local agencies do not have effective nutrition education programs and others are providing little or no nutrition education to WIC participants.

The Service has not provided the States with specific guidelines, criteria, standards, or instructions on how to structure and implement a nutrition education effort that would be of maximum value to WIC participants. The only guidance provided to the States is through the general program regulations, which require that nutrition education emphasize the relationship of proper nutrition to good health and help participants eat better. They also require that the State agencies

--have at least one professionally trained nutritionist or dietician responsible for coordinating, planning, and implementing nutrition education activities throughout the State and

--ensure that local agencies are properly implementing the nutrition education component of the program.

The States are to structure their WIC nutrition education programs within these broad guidelines. The State plans required to be submitted to the Service must list the goals and objectives of the nutrition education component and describe the nutrition education activities to be provided to WIC participants, including:

--What the content of the education will be.

--What teaching methods and materials will be used.

--What evaluation efforts will be undertaken.

The Service's regional offices review these plans for conformance with the regulations and are supposed to monitor each State's program to ensure that the planned nutrition education is properly implemented. The States are, in turn, supposed to guide and monitor the local WIC agencies to ensure that adequate nutrition education is available to program participants.

The nutrition education section of the State plans for the four States we reviewed conformed to program regulations and were approved by the Service. However, some of the nutrition education objectives listed in the plans have not been achieved. One of the major objectives in State plans is to monitor and review the delivery and effectiveness of nutrition education in each local program. None of the four States were fully and effectively accomplishing this objective. New York and Washington State plans also contained program goals for

--providing nutrition education to each WIC participant,

--demonstrating improvements in the health status, dietary intakes, and nutrition knowledge and understanding of WIC participants, and

--providing technical assistance to local programs to help them develop and implement nutrition education.

These goals were not being achieved in most of the local programs we visited in New York and Washington.

About 3 years ago, the Service attempted to develop more comprehensive nutrition education guidelines designed to supplement program regulations and help local agencies in developing a WIC nutrition education component. This was part of a Service effort to develop a handbook for State and local program personnel to use in implementing the WIC program. Although the handbook was never developed, one chapter--dealing with nutrition education--was prepared in draft form. Service officials considered issuing this segment of the handbook to program personnel as nutrition education guidelines, but it was never

finalized and distributed. The segment, although it did not include a detailed discussion on how to structure and implement a good WIC nutrition education component, did contain some information that could have been useful to local program administrators, such as

--the minimum subject matter which should be included in a WIC nutrition education component,

--suggested alternative approaches to providing nutrition education, and

--an explanation of the qualifications needed by the staff dealing with nutrition education.

Service officials told us that this document may be revised and issued to local program administrators after the new legislation is implemented. We think this would be helpful and believe that the Service should develop and include additional information on how to structure and implement an effective nutrition education component, including methods for assessing the benefits of the education given.

Service officials acknowledged that although nutrition education is as important to the program's success as the supplemental food, it has been somewhat neglected. Of about 40 full-time WIC staff members at Service headquarters, no one has been assigned direct operating responsibility for overseeing State implementation of the nutrition education component. This responsibility has been delegated to the Service's regional offices but was not being effectively carried out. Any questions which might arise concerning nutrition education are handled by various Service officials and staff who have backgrounds in nutrition education but who are permanently assigned to different tasks. On the basis of our discussions with Service headquarters officials, there seemed to be a need for someone to provide firm direction to WIC's nutrition education activities on a day-to-day basis.

In developing WIC nutrition education policy and teaching materials, the Service relies on its Nutrition and Technical Services Division for assistance. This group is comprised of experts in the nutrition field and provides advice and technical expertise when requested. Officials of this division told us that they have helped develop both nutrition education materials for WIC and the program regulations.

Service officials stated that, overall, there has not been adequate coordination with HEW in developing the program's nutrition education component, including

--developing and disseminating nutrition education materials and

--developing methods to evaluate the education's usefulness and effectiveness.

Service officials we spoke to agreed that a need exists for systematic coordination among HEW, the Department of Agriculture, and all other agencies involved with nutrition education. They stated that developing a national policy regarding nutrition education and a central clearinghouse for published materials would make nutrition education in general, as well as specifically in the WIC program, more effective and save the Government the unnecessary cost of each agency developing and publishing its own materials.

State involvement

State involvement in the nutrition education component of local WIC programs ranged from good to minimal. The size of the staffs connected with local WIC nutrition education efforts was one indicator of this.

In Louisiana, the State nutritionist was assisted by 21 field nutritionists located throughout the State to monitor and provide guidance to the 21 local WIC programs. In Illinois, the State nutritionist had a field staff of four to monitor the activities of 20 local programs and the State planned to hire four additional nutritionists in 1979. In Washington and New York, the State nutritionists responsible for planning, directing, and coordinating the nutrition education component of the WIC program had no staff to assist in the work. The New York nutritionist told us that she had been spending most of her time trying to recruit nutritionists for local WIC programs 1/ and had been unable to provide much assistance or guidance to local WIC agencies.

The degree of nutrition education guidance provided by the State agencies differed considerably. In Louisiana,

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1/As of December 1978, 8 of the 67 programs operating in the State did not have nutritionists on their staffs, but attempts were being made to fill the vacancies.

the State agency was actively directing and coordinating all WIC nutrition activities throughout the State, although it was not involved in the activities' day-to-day operation. This was the responsibility of each participating WIC agency's community activity workers. The State nutritionist developed the instructional outline and materials used in training the workers on the basis of the State's overall nutrition education plan and the needs of the majority of WIC participants. The training materials were passed on to each field nutritionist for use in conducting monthly training sessions for the community workers. The workers receive basically the same training and are tested on each training session. Although the community workers handle most of the standardized nutrition education provided to WIC participants, any participants who have problems the workers cannot handle are referred to the field nutritionists for assistance.

The Louisiana State agency receives reports from field nutritionists and community activity workers outlining their activities to help monitor local nutrition education efforts. It was also corresponding with and making visits to local health units. Because of a staffing problem, however, some of the visits planned at the time of our review were not expected to be made.

In Illinois, the State agency had prepared and distributed a WIC program manual of operating procedures, policies, and regulations; and four nutritional guides for developing a nutrition health care plan at the local level, but allowed the local agencies to develop their own nutrition education programs. The State agency was trying to monitor local nutrition education efforts through site visits, program reviews, meetings, and reports. It acknowledged, however, that the State has been concentrating on implementing the nutrition education program component and that past evaluation efforts have been limited.

New York and Washington were providing relatively little assistance or guidance on how local WIC agencies should structure the nutrition education components. The State nutritionists said they planned to provide improved nutrition education guidance and monitoring for the local WIC programs in their respective States as soon as available time and resources would permit.

BIG DIFFERENCES IN THE KINDS OF NUTRITION EDUCATION PROVIDED TO WIC PARTICIPANTS

Some WIC agencies we visited were doing a fairly good job of providing nutrition education to participants; others

were doing little or nothing. Only one of the 20 local agencies we reviewed (a New York agency) seemed to have a comprehensive approach to providing nutrition education to WIC participants and offered the kinds of integrated services which we believe should be an essential part of the program. Also, only that one agency was assessing how well individual participants seemed to be progressing in their nutritional education efforts; none of the agencies were evaluating the education effort's overall effectiveness as an integral part of the WIC program. Only six local WIC agencies required monthly participation in nutrition education as a condition to receiving the supplemental food. Additionally,

--four agencies had no nutritionists on their staffs,

--seven agencies did not have kitchen facilities for cooking and tasting demonstrations,

--one agency provided only printed nutrition education materials to participants, and

--one agency offered no nutrition education at all.

The following State-by-State discussion of the nutrition education being provided by the local clinics we visited illustrates the problems that exist when there is inadequate Federal and State involvement in such an important area.

New York

Large differences exist in the extent and type of nutrition education provided in the local agencies we visited in New York.

One New York agency had effectively integrated its nutrition education into its total WIC program and offered educational services that were the best we saw during our review. The staff dealing with nutrition education at this agency consisted of a nutritionist and three nutritionist aides, serving about 580 participants. Each month the staff developed new education plans designed to address various nutrition-related topics. The lesson presentations varied from films and lectures for adults to puppet shows for children. At least once a week, the staff gave nutrition education lessons for pregnant women as well as general nutrition sessions for children. Special attention and educational emphasis was given to individuals experiencing less than satisfactory growth patterns or having poor eating habits.

The agency's clinic had kitchen facilities where participants were taught how to properly cook the supplemental WIC food; recipes suggesting different ways of using the supplemental food were distributed at each session. After each lesson, the participants were quizzed by the clinic staff on what they had learned that day. The results of these quizzes were used to assess individual participant's progress and needs.

This agency required participation in nutrition education activities. Parents or guardians of WIC children also had to receive these lessons. If a participant did not attend the monthly nutrition education session, the participant did not receive a food voucher.

The few participants we interviewed at this clinic expressed satisfaction with how the WIC program was operated and with their participation in the clinic's nutrition education activities. They said that they believed the nutrition education was effective and that they were benefiting from their participation.

--One woman with high blood pressure said that she was instructed on what foods to eat to curb her salt intake, and stated she learned which foods provided the vitamins and protein needed to address her special nutritional needs.

--Three women said that they learned proper infant feeding practices, including when to start feeding their infants solid foods.

In contrast with the nutrition education focus of the above agency, the nutrition education component of two other New York clinics we visited were minimal. One of these clinics was one of six satellite clinics run by a county health department that operated the WIC program. The county health department had only one WIC nutritionist for about 2,700 participants at all six satellite clinics. The nutritionist told us that because of the large caseload and the lack of assistance by nursing personnel at the satellite clinics, it was impossible to provide nutrition education to every WIC participant.

Of 25 participant cases we reviewed at this clinic, only 7 indicated that some nutrition education was received. The nutritionist told us that of the total 580 WIC participants at this clinic, only 344 participants have received any nutrition education. We were unable to obtain more information on the extent of nutrition education

received by the participants because documented information was not available. Several participants we interviewed said the nutrition education they received was helpful, but they were unable to give any details.

The other agency's clinic did not have a nutritionist on its WIC staff at the time of our review, but was trying to hire one. In the meantime, a clerk was simply distributing some nutrition education materials to the participants. Three participants that we talked with said that they had received nutrition-related literature which was helpful but had not received any nutrition counseling.

The two remaining New York WIC agencies we visited offered nutrition education counseling to participants every month when they picked up their food vouchers. Lessons on various nutrition-related topics were offered each month on a group and individual basis. One of these agencies did not have cooking facilities, but the other one did, and gave cooking and tasting demonstrations. Of seven participants we talked with at these two agencies, six said they received some helpful nutrition education through the WIC program, but could not explain more precisely how they benefited. The other participant said she had not received any nutrition education.

Only the one New York agency discussed at the beginning of this section made any attempt to assess the effectiveness of the nutrition education given to individual participants. We believe that if the staff had gone one step further and compiled the results of the individual participant data into an overall analyses or evaluation of the nutrition education's effectiveness, it would have had a total picture of the program's results and a better indication of the success or failure of its efforts.

Washington State

Many WIC participants at some of the agencies we visited in Washington were receiving little or no nutrition education or the extent of nutrition education received could not be determined.

Three of the five WIC agencies we visited had nutritionists on their staffs who provided nutrition education to participants. This usually involved counseling sessions with participants on proper diet and food preparation and distribution of nutrition-related literature. No food preparation or tasting demonstrations existed and no attempts were made to assess the effectiveness of the nutrition education

provided. Of 13 participants we talked with at three clinics, 11 said that they received some nutrition education that was beneficial and helped improve their eating habits. Two participants said they did not receive any nutrition education.

The fourth agency we visited did not have a nutritionist on its staff. Clinic staff told us that although all WIC participants were urged to go to the nutrition education classes offered by their local county health departments, the staff did not verify if the participants were attending such classes. The 25 sample cases we reviewed at this clinic had no information as to whether the participants were receiving nutrition education.

At the fifth WIC agency, one clerk handled all administrative and nutritional matters for about 850 WIC participants. The clerk had no formal nutrition training and relied on her own experience as a mother to provide nutrition education. The medical director and the clinic's administrator agreed that nutrition education would benefit WIC participants, but said that they could not provide it without additional administrative funding.

Illinois

Nutrition education was offered at each of the five local agencies we visited in Illinois. Each program had structured nutrition education lessons addressing both individual nutritional needs as well as general nutrition topics. The programs offered workshops on cooking and preparing the supplemental food, along with tasting demonstrations.

Illinois required participation in nutrition education activities as a condition to receiving WIC supplemental food. However, participants were only required to receive this education at the time of certification and recertification. Also, the nutritionists at the local agencies were not assessing the effectiveness of the nutrition education provided to participants.

Of 21 WIC participants we talked with in Illinois, 15 stated they had benefited from the nutrition education because they learned

--which foods were more nutritious,

--when to introduce certain foods to infants, and

--what types of food pregnant women should eat.

Of the remaining six participants, two said they had not yet received any nutrition education and four stated that they had not benefited from the education received.

Louisiana

The WIC nutrition education program at the five clinics we visited was generally standardized. Individual sessions as well as group sessions were held. Four of the clinics held cooking and tasting demonstrations (one clinic did not have kitchen facilities) and recipes were distributed to participants on suggested ways of preparing nutritious foods.

Louisiana, like Illinois, had a State requirement that participants receive nutrition education, but only at 3-month intervals at the time of program certification and recertification. Also, the WIC staffs made no attempts to assess the effectiveness of the nutrition education provided.

Eighteen of the 20 WIC participants we talked with in Louisiana expressed satisfaction with the nutrition education they received. Two participants said they had not yet received any education. Generally the participants said that they thought the education was beneficial and increased their knowledge of nutrition. Two participants said that they have changed their eating habits because of the education.

RECENTLY ENACTED LEGISLATION AND PROPOSED REGULATIONS STRENGTHEN WIC NUTRITION EDUCATION

The recently enacted Child Nutrition Amendments of 1978 strengthen provisions relating to WIC's nutrition education component. The amendments show that the Congress is aware of the critical role such education plays in ensuring that WIC participants' individual needs are met. The new legislation requires that

- --the State agency ensure that nutrition education is provided to all program participants, including the parents or caretakers of infants and child participants;

- --the State agency provide training to persons teaching nutrition education and annually evaluate the nutrition education given (this evaluation must consider participants' views concerning the effectiveness of the education received);

- --the Secretary of Agriculture prescribe standards to ensure that adequate nutrition education services are provided;

--not less than one-sixth of the Federal funds given to each State for administering the WIC program be used for nutrition education activities; and

--the Secretary of Agriculture submit proposed nutrition education materials to the Secretary of Health, Education, and Welfare for comment before issuing such materials for program use.

The new legislation's intent is to require that nutrition education be an integral part of the WIC program and that it be so thoroughly integrated into program operations that all participants would receive it on a routine basis. Regulations recently proposed by the Service to implement the new legislation seem to strengthen the nutrition education component at the State and local levels. The proposed regulations would require that the State agencies provide additional assistance to local WIC staffs in terms of training, educational materials, and closer monitoring and evaluation of local nutrition education programs. The local agencies would be required to prepare a local nutrition education plan to be reviewed by State agency officials detailing how this education will be provided. The proposed regulations would further require that all adult WIC participants and the parents or caretakers of infant and child participants be given a basic nutrition education contact at the local program. The contact would be required to discuss with these adults the participants' nutritional risk condition, ways to achieve an adequate diet, the supplemental food's importance to the participant, and the importance of health care.

The proposed regulations specify that WIC participants could not be denied the supplemental food because of failure to attend or participate in nutrition education activities; however, local agencies are required to make all reasonable efforts to provide some nutrition education to each participant. We believe that such a prohibition would be counterproductive to the Department of Agriculture's stated goals and local WIC agencies efforts to thoroughly integrate nutrition education into participant health care plans and the delivery of supplemental WIC food. Ideally, nutrition education should be so fully integrated into overall WIC program operations that participants would not need to consciously choose between attending nutrition education sessions or being denied the supplemental food package.

CONCLUSIONS

For the program to operate as the Congress intended, nutrition education must be thoroughly integrated into program operations. The Food and Nutrition Service must give more priority to this program component than it has in the past and provide more specific guidance and direction to State and local WIC agencies. The Service needs to improve its coordination with HEW in developing and implementing an appropriate WIC nutrition education policy. Coordination of this type would also assist the Service in preparing, distributing, and updating nutrition education materials to State WIC agencies.

The proposed regulations for implementing the Child Nutrition Amendments of 1978 need to be revised to permit States to require nutrition education as a condition of receiving supplemental food. If this revision is made and is properly implemented, the regulations should help integrate nutrition education into the program as the Congress intended.

RECOMMENDATIONS TO THE SECRETARY OF AGRICULTURE

We recommend that the Secretary of Agriculture

--Provide more specific guidance and direction to the States--and through the States to the local programs--as to how to structure and implement an effective nutrition education program for WIC participants. Part of this effort should entail designating a Service headquarters official responsible for the nutrition education component of the WIC program. It also should involve close coordination with HEW to develop and implement an appropriate nutrition education policy and to prepare, distribute, and update related teaching materials for the WIC program.

--Drop from program regulations the proposed provision that participants not be denied supplemental food for failure to attend or participate in nutrition education activities. In light of the need for local WIC programs to fully integrate nutrition education into WIC program regulations, such restrictions on methods by which this can be effectively accomplished would be counterproductive and at odds with program goals.

--Require that the Department evaluate and report on State monitoring of the content and overall effectiveness of nutritional education given to participants at the local level.

AGENCY COMMENTS AND OUR EVALUATION

The Department of Agriculture agrees that nutrition education should be thoroughly integrated into participant health care plans and the delivery of supplemental food, but believes that the burden for accomplishing this should be on State and local program administrators and that attendance or participation in nutrition education activities should be left up to the participants. We believe that nutrition education--being a major program goal--should be made part of the total program package and that the Department should provide all necessary guidance, assistance, and oversight to insure that this is accomplished in the most effective way possible.

CHAPTER 5

PROGRAM EVALUATION SHOULD BE IMPROVED

Reliable assessments of WIC's overall results and benefits have not been made. The broader evaluations that have been conducted, while providing some information that may be useful, have had various problems affecting their reliability. The more limited studies, including those conducted by various States, are generally of uncertain quality and reliability. The Congress has emphasized the importance of good program evaluations in various hearings and in the Child Nutrition Amendments of 1978.

Although the Food and Nutrition Service recently took steps to improve its evaluations of WIC, its WIC regulations contain provisions which could hinder future evaluations--as they hindered our efforts during this review. These provisions restrict access to information on program participants' health status and justify such restriction on the basis of confidentiality. We recognize that access to this kind of information should be limited, but we believe that this can and should be done in ways that would not present obstacles to evaluations of program operations and results by the Department of Agriculture, the General Accounting Office, and other authorized agencies.

EVALUATION OF PROGRAM RESULTS HAS BEEN WEAK

Due to the WIC program's large size and likely expansion and its objective to maintain and improve the health of mothers, infants, and children, a key element of the program's overall administration should be thorough and reliable evaluations of program results. The Congress has recognized the importance of program evaluation in various hearings and by including special funding for it in the November 1978 child nutrition amendments. The Service also appears to have recognized the importance of good program evaluation by recently developing detailed evaluation plans.

Because WIC's prime objective is to maintain and improve participants' health status, evaluations of program results must focus on changes--hopefully improvements--in participants' health status after they begin receiving various program benefits. The only major evaluations which have attempted to do this have been (1) HEW's Center for Disease Control's special analysis of data from its ongoing nutrition surveillance program and (2) a medical evaluation performed for the Service, on a one-time basis, by the Department of Nutrition, School of Public Health, University of North Carolina at Chapel Hill.

We reviewed the University of North Carolina evaluation and reported our results in an earlier report entitled "Observations on the Special Supplemental Food Program, (RED-75-310, Dec. 18, 1974). In this report we concluded that due to weaknesses in training of staff responsible for conducting tests on participants, pretest procedures, and procedures for controling data quality, the reliability of the data collected and any findings based on the data were questionable.

As of January 1979, 14 States and three metropolitan areas were voluntarily participating in a nutrition surveillance program through which State health departments obtain height, weight, hemoglobin, hematocrit, and other pertinent nutrition data on individuals from clinics administering WIC and other programs which serve potentially high-risk groups. The Center for Disease Control analyzes the data and reports the results to the States, which in turn use the data to support and evaluate local program operations. The only data used is that obtained by clinic personnel in the normal course of patient care.

Under a 1976 contract with the Service, the Center made an analysis based on data for all WIC infants and children in Arizona, Kentucky, Tennessee, Washington, Oregon, and Montana made available through clinics participating in the nutrition surveillance system. The Service compiled the results of this analysis into report form to demonstrate the WIC program's health benefits. The Advisory Committee on Nutrition Evaluation, however, criticized the validity of the nutrition surveillance program's data gathering mechanisms. This committee was established by WIC's authorizing legislation to study and make recommendations to the Secretary of Agriculture on methods available to evaluate WIC's health benefits. The advisory committee criticized the nutrition surveillance program because of problems with

--the quality control of the data being collected,

--the training of individuals conducting the program--resulting in erroneous interpretation of the data collected, and

--the results obtained, which cannot be considered representative of the Nation's population.

Also, the States included may not be representative inasmuch as participation is voluntary and may impose a "self-selection" bias.

Several States and local agencies have conducted studies to evaluate WIC's health benefits and, in May 1977, the Service requested the States to send it the results of these studies. The Service received 12 studies from 10 States and the Virgin Islands and compiled them into one document, but it has not attempted to combine the data from these studies or draw conclusions from them. The results of these studies cannot be projected to a national, or even in some cases, to a State level. The quality and reliability of the State studies have not been independently evaluated and are generally uncertain.

One exception is a study made by Louisiana in connection with its overall nutrition surveillance program. (See p. 6) This study showed significant benefits attributable to the WIC program in Louisiana but did not attempt to assess the program's nationwide benefits or the relationship of the Louisiana program's results to the results of any other State's program. We were told by a former member of the Advisory Committee on Nutrition Evaluation that it is one of the most reliable studies available for showing the program's impact.

The Congress emphasized the importance of program evaluation in WIC on at least two occasions in 1978. The child nutrition amendments, enacted November 10, 1978, provide that one-half of 1 percent of the program's total appropriation, not to exceed $3 million, shall be available for evaluating program performance and health benefits and for administering pilot projects. Also, in connection with its March 1978 hearings on the Department of Agriculture's fiscal year 1979 appropriations request, the Subcommittee on Agriculture, Rural Development, and Related Agencies of the Senate Appropriations Committee questioned the adequacy of previous program evaluations and the Service's plans for future evaluation studies.

In responding to the Appropriation Subcommittee's specific questions, the Service agreed to summarize previous studies, including discussions of the source and reliability of each study, and to implement several recommendations submitted by the Advisory Committee on Nutrition Evaluation. Service officials advised us that they have issued several summary reports on WIC studies, have started to implement one of the advisory committee's recommendations, and are considering actions to implement another of its recommendations as described below.

The Service has entered into a contract with the Center for Disease Control to develop a detailed proposal for

improving the data collection methods used in the nutrition surveillance program. The Service hopes to obtain more and better information on WIC participants through the improved system. The Service is also considering a more in-depth study in which more sophisticated and precise methods than those used in the nutrition surveillance program would be used to assess WIC's impact on a relatively small number of participants over an extended but definite time period. The Service's work on specifications for this study started in November 1978 and is to be completed before the end of 1979.

SERVICE REGULATIONS HINDER EFFECTIVE PROGRAM EVALUATION

Meaningful evaluations of WIC's results would require access to information about participants' health status. Yet WIC program regulations provide that neither the Department of Agriculture nor GAO shall have access to participants' health care and medical records unless these records are the only information source available for verifying participants' eligibility. The regulations also provide that the Service may require WIC agencies to supply information from such participants' records in a form that does not identify individuals.

Service personnel told us that the intent of these two provisions was to protect participants' privacy by preventing both the Department's internal auditors and GAO from getting access to medical records and by preventing the Service from getting information which could be related to individual participants' names. Service personnel also told us that requiring WIC agencies to provide health and medical information (from all health care providers) as stated in the regulations would be quite burdensome.

The Service's regulations on access to participants' medical records do not seem to be necessitated by, or even consistent with, the program's authorizing legislation, especially the 1978 amendments. The legislation prior to the 1978 amendments required that State and local agencies maintain adequate participant medical records to enable the Department to determine and evaluate program benefits. The Child Nutrition Amendments of 1978 add to this a new requirement that these records be available for inspection and audit at all times by Department representatives. It seems clear that the legislation intended that the Department have access to participants' medical information. The 1978 amendments in particular raise serious questions

concerning the validity of the Service's regulations in this regard. Regulations recently proposed by the Service to implement the 1978 amendments contain the same restrictions as the existing regulations.

Although the Department has not attempted a detailed evaluation of the program's health benefits, which would require reviewing the participants health and medical progress, the provision in the regulations governing access to this information might hinder future evaluations as it did ours. Of the 500 WIC participants we selected for review, we were denied access to health status information for 107; 12 in New York, 48 in Illinois, and 47 in Washington. In most cases, the denials were because of health service providers' concern about the confidentiality of such information, despite our promises to protect individual participant's privacy.

As discussed previously, health data on several States' and localities' WIC participants is provided to HEW's Center for Disease Control for analysis and evaluation. It seems incongruous to us that the Service's regulations permit this free flow of information on participants' health status while restricting its own access to this information and prohibiting access by Department of Agriculture auditors and GAO.

We agree that it would not be appropriate to publicize WIC participants' medical information, but we also believe that program evaluation is important and requires access to this information to assess various program aspects, especially overall results. Accordingly, we believe that authorized evaluators should be given access to the information while being required to safeguard its confidentiality.

In our case, a precedent has been established for access to such information. The Medicare-Medicaid Anti-Fraud and Abuse Amendments (42 U.S.C. 1305, et seq.) provide our general right of access to participants' medical records. In enacting this law, the Congress placed strict controls on how we could use the medical information to prevent any compromising of participants' privacy and the information's confidentiality.

Although this law does not apply to WIC, it provides the Service with a precedent for revising its regulations to allow access to participants' medical records. Although the regulations should provide the Department's auditors and GAO access to medical information needed for program evaluation, they should at the same time provide sufficient

restrictions on the information's use to protect participants' privacy. The regulations could provide, for example, that published information be presented in such a way that it would be impossible to determine individual participants' identities.

In addition, if legislation is enacted requiring participants to receive health services where available, accessible, and acceptable as a condition of program participation, the Department of Agriculture will need access to participants' medical information to verify that they have received such services.

CONCLUSIONS

Although reliable evaluations of WIC's overall results have not been conducted, the Food and Nutrition Service's recent efforts seem to be a step in the right direction. Hopefully, these efforts will lead to reliable evaluations which will provide information on the program's overall benefits and on which program aspects and techniques are the most beneficial and cost effective.

RECOMMENDATION TO THE SECRETARY OF AGRICULTURE

To ensure that future legitimate program evaluators have access to needed information on participants' health status, we recommend that the Secretary of Agriculture direct the Service to revise its regulations to give Department of Agriculture and GAO personnel access to participants' medical information, but require that these personnel protect the privacy of the participants.

AGENCY COMMENTS AND OUR EVALUATION

The Department of Agriculture does not agree that we should be given access to participants' medical information, especially if it is not in the hands of the local WIC agency. Department officials believe that such information is confidential and that private physicians and other sources of health service should not be required to divulge it. The officials said that any information that we may need should be in the WIC eligibility certification records.

In our review of 500 cases in four States, we found that certain information we needed to evaluate the program could be obtained only from participants' medical records. In most cases, it was not necessary for us to read the medical

records ourselves because responsible health professionals gave us the information we needed based on their reviews of the records. Information on whether a participant is receiving health services, for example, and the effects of those services--necessary information for evaluating the program's results--were not available in eligibility certification records.

CHAPTER 6

SCOPE OF REVIEW

We reviewed the legislation and regulations governing the WIC program's authorization and operation. We also reviewed the policies, practices, and procedures of State and local offices operating the WIC program, as well as those of the health clinics providing health services to program participants. Our purpose was to determine whether

- --assessments of nutritional risk were being made by competent professionals and if the necessary related health services were available to WIC participants as fully and frequently as necessary,
- --participating health clinics were tailoring food packages to the participants' individual needs,
- --useful nutrition education was being effectively provided to all WIC participants, and
- --reliable evaluations of program results had been conducted.

We made our review at State and local WIC program offices in New York, Illinois, Louisiana, Washington, and the Seneca Nation Indian Reservation. We also did work at the Food and Nutrition Service headquarters in Washington, D.C. and at four of its regional offices--Robbinsville, New Jersey; Chicago, Illinois; Dallas, Texas; and San Francisco, California. Work was also conducted at HEW headquarters in Washington, D.C., and at four of its regional offices--New York, New York; Chicago, Illinois; Dallas, Texas; and Seattle, Washington.

At each of the 20 local health clinics we visited, we tried to obtain medical information on the health status of 25 selected WIC participants (15 women and 10 infants or children) and trace the selected participants' progress from the certification date to the time of our review. In addition, we tried to interview three to six participants at each clinic. The clinics we visited are listed in appendix IV.

We obtained the assistance of local program medical professionals (physicians or nurses) to interpret the selected participants' medical records to see if the participants were receiving health care as fully and frequently as needed. We also solicited the opinions of health professionals at each clinic to ascertain the reasons for selected participant's program eligibility and to identify what benefits these

participants were deriving from the program. The confidentiality of the medical records information has remained secure at all times.

We obtained the services of an outside expert 1/ in the field of maternal child health and consulted with our medical advisor to assist us in our work and assure technical accuracy.

AGENCY COMMENTS AND OUR EVALUATION

The Department of Agriculture said that our review scope and approach were inappropriate and our review results not indicative of nationwide problems.

We believe our report presents considerable information on program-wide problems that need attention and resolution. The four States we selected represent different geographic areas and the five local WIC programs selected in each State include two urban programs, two rural programs, and one suburban program. We discussed our selection of States with agency officials before starting our review. Also, at the suggestion of agency officials, we included a migrant health clinic and an Indian reservation clinic in our selection. We tried to provide coverage of different kinds of local WIC programs in different parts of the country.

1/Dr. Howard Jacobson, a consultant during this review, is associated with nutrition in maternal and child health. At the time of our review he was Professor of Community Medicine at Rutgers University, New Jersey, and subsequently was appointed as Director of the Institute of Nutrition, University of North Carolina. He served as a member of the Advisory Committee on Nutrition Evaluation which was established by legislation to determine and evaluate how the WIC's health benefits may be best assessed and evaluated. He also has held positions at the University of California Medical Center in San Francisco and the University of California, Berkeley; directed the Macy Program at Harvard Medical School; was an associate professor at the Boston Hospital for Women, Department of Obstetrics and Gynecology, Harvard University; and served as Chairman of the Committee on Maternal Nutrition, National Research Council, National Academy of Sciences.

While our review coverage does not provide scientific assurance of being representative of all of the Nation's local WIC programs, it does identify important weaknesses in the program's administrative system and its implementation at Federal, State, and local levels.

WIC INCOME STANDARDS USED IN STATES AND CLINICS VISITED AND IN FISCAL YEAR 1979 PROGRAM LEGISLATION

Income standard in FNS WIC regulations (8/77)	New York	Illinois and Louisiana	Washington	1979 WIC program legislation
Recipients shall meet an income standard provided or approved by the State agency. If none are so provided or approved, recipients shall be eligible for health care free or at less than the full charge customarily made for health services by the local agency. (FNS 246.7 (b)(2)(i))	State income standard: Any individuals eligible for free or reduced price health care. This to be at discretion of clinics.	State income standard: 195 percent of the poverty guidelines established for free or reduced price school meals.	State income standard: Any individuals eligible for free or reduced price health care, receiving public assistance or food stamps, or having an income that did not provide for the purchase of adequate amounts of food because of excessive debt or expenses.	Persons at nutritional risk shall be eligible for the program only if they are members of families that satisfy the income standards prescribed for free and reduced price school meals under section 9 of the National School Lunch Act. Such income guidelines for reduced-price lunches shall be prescribed at 95 percent above the applicable family size income poverty guidelines prescribed by the Secretary of Agriculture.
	Two clinics set income standards at 195 percent of the poverty guidelines established for free or reduced price school meals. Another clinic set its income standard at 5 percent less than the poverty guidelines. One clinic considered all persons living in the neighborhood of the clinic eligible for free or reduced price health care. The Seneca Nation clinic considered all residents of the reservation eligible for free health care.	Clinics visited in these States were using the State standard.	Clinics visited were using income standards at or below 195 percent of the poverty guidelines established for free or reduced price school meals.	

GAO note: Income poverty guidelines for the 48 States, District of Columbia, and Territories (excluding Guam) are in appendix II.

APPENDIX I

APPENDIX II

INCOME POVERTY GUIDELINES

For 48 States, District of Columbia, and Territories (excluding Guam)

Family size	7-1-77 to 6-30-78 Poverty levels	7-1-77 to 6-30-78 195 percent of levels	7-1-78 to 6-30-79 Poverty levels	7-1-78 to 6-30-79 195 percent of levels
1	$ 3,140	$ 6,120	$ 3,350	$ 6,530
2	4,130	8,050	4,400	8,580
3	5,110	9,970	5,450	10,630
4	6,090	11,880	6,490	12,660
5	6,990	13,630	7,450	14,530
6	7,890	15,380	8,410	16,400
7	8,710	16,980	9,280	18,100
8	9,530	18,580	10,150	19,790
9	10,270	20,030	10,940	21,330
10	11,010	21,470	11,730	22,870
11	11,740	22,890	12,510	24,390
12	12,470	24,310	13,290	25,910
Each additional member	730	1,420	780	1,520

WIC NUTRITIONAL NEED CRITERIA USED IN STATES REVIEWED AND AS ESTABLISHED BY PROFESSIONAL ORGANIZATIONS

Nutritional risk category	Illinois	Louisiana	New York	Seneca Nation	Washington	Criteria established by professional organizations (note a)
WOMEN						
Age	less than 18 years	less than 18 years	19 years or less	17 years or less	less than 18 years	15 years or less
	over 35 years	over 35 years	35 years or more	36 years or more	over 40 years	-
Anemia:						
hematocrit	38 and below	less than 34	37 and below	33 and below	33 and below	33 and below (low) / less than 30 (deficient)
hemoglobin	13 and below	less than 11	12 and below	11.6 and below	less than 11.5 first 6 months less than 10.5 last 3 months	less than 11 / less than 10
Irregular Growth:						
pre-pregnancy	abnormal weight gain pattern	overweight or underweight	weight less than 25th percentile or greater than 75th percentile	irregular growth pattern	underweight or obese	weight less than 85 percent or greater than 120 percent of standard weight
weight gain during pregnancy:						
first trimester inadequate	abnormal weight gain pattern	overweight or underweight	less than 3 lbs.	-	less than 2 lbs.	less than 2 lbs. per/mo.
excessive	abnormal weight gain pattern	-	more than 5 lbs.	obesity	-	more than 2 lbs. per/week
thereafter inadequate	abnormal weight gain pattern	-	less than 3 lbs. per/mo.	-	less than 2 1/2 lbs. per/mo.	Same as in first trimester
excessive	abnormal weight gain pattern		more than 5 lbs. per/mo.	obesity	-	-
Past history:						
high parity	multiple births	4 or more deliveries	more than 3 pregnancies by 21 more than 4 pregnancies		-	3 or more pregnancies during past 2 years
short interval between pregnancies	short interconceptional period	less than 18 mos.	less than 18 mos. (2 yrs. for multiple births)	-	less than 2 yrs.	

APPENDIX III

	Illinois	Louisiana	New York	Seneca Nation	Washington	Criteria established by professional organizations (note a)
Past history:						
other factors in prior pregnancies	-	-	-	-	-	poor obstetric or fetal performance in prior pregnancies
	miscarriage/ abortion	miscarriage/ abortion	miscarriage or spontaneous abortion	miscarriage	miscarriage	-
	prematurity	prematurity	history of prematurity/ postmaturity	premature birth	prematurity	-
	history of low birthweight infants	low birthweight	low birthweight infants	-	low birthweights	-
	-	toxemia	toxemia	toxemia	toxemia	-
	pre-eclampsia	pre-eclampsia	-	-	pre-eclampsia	-
	-	stillborn	perinatal death	-	-	-
	C-section	C-section	-	-	-	-
	-	infant with congenital abnormality	-	-	-	-
Factors in current pregnancy						
	-	-	-	-	-	prescribed a therapeutic diet for chronic systemic disease
	-	-	-	-	-	economically deprived
	inadequate diet	inadequate diet	inadequate diet	inadequate nutritional pattern	inadequate diet	-
	-	toxemia	toxemia	toxemia	toxemia	-
	pre-eclampsia	pre-eclampsia	-	-	pre-eclampsia	-

APPENDIX III

	Illinois	Louisiana	New York	Seneca Nation	Washington	Criteria established by professional organizations (note a)
Factors in current pregnancy (continued)						
	chronic illness	-	frequent illness or chronic disease	-	-	-
	-	chronic hypertension	hypertension	-	chronic hypertension	-
	-	diabetes	diabetes	-	chronic diabetes	-
	-	heart disease	cardiovascular disease	family history of cardiovascular problems	chronic heart disease	-
	-	-	substance abuse	drug abuse	substance abuse	heavy smoker, drug addict, alcoholic
	-	sickle cell disease	sickle cell disease	-	-	-
	-	tuberculosis	pulmonary disease	-	-	-
	-	metabolic disease	metabolic disorders	-	-	-
	-	-	-	family history of diabetes	-	-
	-	chronic urinary tract infection	-	-	-	-
	-	malignancy	-	-	-	-
	-	-	-	alcoholism	-	-
	-	-	-	needs supplement to maintain adequate growth and nutrition	-	-
	-	-	renal disease	-	-	-
	-	-	liver disease	-	-	-

APPENDIX III

Factors in current pregnancy (continued)	Illinois	Louisiana	New York	Seneca Nation	Washington	Criteria established by professional organizations (note a)
	-	-	gastrointestinal disease	-	-	-
	-	-	food allergies	-	-	-
	-	-	emotional disorders psycho/physical handicaps affecting feeding	-	-	-
	-	-	congenital disorders	-	-	-
	-	-	mental retardation	-	-	-
	other	-	other	other	-	-

APPENDIX III

Nutritional risk category	Illinois	Louisiana	New York	Seneca Nation	Washington	Criteria established by professional organizations (note a)
INFANTS						
Anemia						
hematocrit	34 and below	34 and below	34 and below	33 and below	less than 31	below 34
hemoglobin	11 and below	11 and below	11 and below	11.6 and below	less than 10	below 11
Birthweight	low birthweight	less than 2500 gms. or 5 1/2 lbs. regardless of gestational age	less than 2501 gms.	-	less than 2500 gms.	-
Growth (note b):						
length/height for age	-	less than 10th percentile	less than 10th percentile	less than 15th percentile	inadequate pattern of growth such as stunting	-
weight for age	-	-	less than 10th percentile	under 20th percentile over 90th percentile	inadequate pattern of growth such as obesity	-
weight for length	25th percentile or less 75th percentile or more	-	under 25th percentile over 90th percentile	under 20th percentile over 90th percentile	-	-
weight for height	50th percentile or more	under 10th percentile over 90th percentile	-	under 20th percentile over 90th percentile	under 5th percentile over 95th percentile	-
difference between height and weight	50th percentile or more	height and weight less than 3rd percentile with hemoglobin less than 9 and hematocrit less than 28	other deficient pattern over time	-	-	-
Other						
	premature	premature	premature	-	premature	-
			postmature			
	infant of a WIC mother	infant of a WIC mother	infant of a WIC mother	infant of a WIC mother	infant of a WIC mother	-

APPENDIX III

	Illinois	Louisiana	New York	Seneca Nation	Washington	Criteria established by professional organizations (note a)
Other (continued)						
	inadequate diet	poor diet or inadequate nutrition	inadequate diet	-	inadequate nutrit	-
	chronic respiratory infection	-	chronic lung disease	-	cystic fibrosis	-
	-	chronic disease	chronic illnesses	-	chronic disease	-
	-	-	lead poisoning	excessive lead intake	-	-
	teenage mother high risk mother	teenage mother (less than 18)	-	-	-	-
	one of multiple birth	-	-	-	-	-
	-	-	diabetes	-	diabetes	-
	-	-	congenital abnormalities	-	heart defects and other congenital problems	-
	breast feeding mother is anemic	mother anemic during pregnancy	-	-	-	-
	breast feeding mother	-	-	-	-	-
	-	-	physio/emotional and phychological conditions	-	-	-
	-	-	renal disease	-	-	-
	-	-	frequent infections	-	-	-
	-	-	dental condition	-	-	-
	-	-	sickle cell disease	-	-	-
	-	-	-	-	PKU (note c)	-
	-	mother over 35 at time of other pregnancy	-	-	-	-
	other	other	-	-	-	-

APPENDIX III

Nutritional risk category	Illinois	Louisiana	New York	Seneca Nation	Washington	Criteria established by professional organizations (note a)
CHILDREN						
Anemia						
hematocrit	34 and below	34 and below	36 and below	33 and below	less than 31 (12-23 mos.)	below 34
					less than 34 (2-5 yrs.)	
hemoglobin	11 and below	11 and below	12 and below	11.6 and below	less than 10 (12-23 mos.)	below 11
					less than 11 (2-5 yrs.)	
Growth pattern (note b)						
length/height for age	less than 25th percentile	less than 10th percentile	less than 10th percentile	less than 15th percentile	low height and weight for age	-
	more than 75th percentile					
weight for age	low birthweight to 2 yrs.	-	less than 10th percentile	under 20th percentile over 90th percentile	-	-
weight for length/ height	more than 25th percentile difference	under 10th percentile over 90th percentile	under 25th percentile over 90th percentile	under 20th percentile over 90th percentile	less than 5th percentile above 95th percentile	-
Medical						
	chronic upper respiratory illness (more than 3 per yr.)	-	chronic lung disease	-	cystic fibrosis	-
	-	chronic disease	chronic illnesses	-	chronic disease	-
	-	-	congenital anamolies	-	congential problems	-
	-	-	diabetes	-	diabetes	-
	premature	-	-	-	-	-
	low birthweight (to 2 yrs.)	-	-	-	-	-

APPENDIX III

	Illinois	Louisiana	New York	Seneca Nation	Washington	Criteria established by professional organizations (note a)
Medical (continued)						
	Adolescent mother (to 2 yrs.)	-	-	-	-	-
			-	-	heart defects	-
	-	-				
	-	-	-	history of diabetes in family	-	-
	-	surgery	-	-	-	-
	-	-	renal disease	-	-	-
	-	-	frequent infections	-	-	-
	-	-	dental conditions	-	-	-
	-	-	sickle cell disease	-	-	-
	-	-	emotional, psychological and physiological conditions	-	-	-
	-	-				
			-	-	PKU (note c)	-
Other	inadequate nutrition	inadequate nutrition	inadequate nutrition	-	inadequate nutrition	-

a/Criteria for nutritional risk categories for women are established by the American College of Obstetricians and Gynecologists. The professional organization for infants and children, the American Academy of Pediatrics, had not established similar criteria, however, the World Health Organization has established anemia levels for infants and children.

b/National Center for Health Statistics growth charts, endorsed by HEW, were used by New York, Louisiana, and Washington. The Ross growth charts, published by Ross Laboratories, were used by Illinois and the Seneca Nation.

c/Abbreviation for Phenylketonuria.

APPENDIX III

APPENDIX IV

LIST OF HEALTH FACILITIES REVIEWED

State	Name of facility	Classification	Approximate number of active WIC participants
New York	Northeast Neighborhood Association (NENA) Comprehensive Health Service Center	Urban	250
	Montefiore-Morrisania Hospital Comprehensive Health Care Center	Urban	2,030
	Suffolk County Department of Health-South Brookhaven Health Center	Suburban	580
	Livingston County Health Department	Rural	560
	Seneca Nation Health Department Cattaraugus Clinic	Rural	400
Illinois	Mile Square Health Center	Urban	2,270
	Chicago Board of Health-Station 30	Urban	1,260
	Fulton County Health Department	Rural	1,200
	Vermilion County Health Department	Rural	620
	Community and Economic Development Association-Chicago Heights Service Center	Suburban	1,660

APPENDIX IV

State	Name of Facility	Classification	Approximate number of active WIC participants
Louisiana	Bossier Parish Health Unit	Urban	890
	Quachita Parish Health Unit	Urban	2,090
	Washington Parish Health Unit	Rural	860
	Tangipahoa Parish Health Unit	Rural	1,060
	Maternal and Infant and Children and Youth Projects	Suburban	990
Washington	Southwest District Health Center	Urban	800
	Pregnancy Aid	Suburban	960
	Odessa Brown Children's Clinic	Urban	840
	Farmworkers' Family Health Center	Rural	1,000
	Northeast Tri-County Clinic	Rural	140

APPENDIX V

United States Senate
COMMITTEE ON APPROPRIATIONS
WASHINGTON, D.C. 20510

May 11, 1978

The Honorable Elmer B. Staats
Comptroller General of the United States
General Accounting Office
Washington, D. C. 20548

Dear Mr. Staats:

The Subcommittee appreciates the timely assistance provided by the GAO staff in connection with the Department of Agriculture's Special Supplement Feeding Program for Women, Infants and Children (WIC). The staff summary of major issues and questions was very helpful, as was your formal report on entitlement funding in general and its use in the case of the WIC program.

In view of the major expansion proposed for WIC, the Subcommittee would like GAO staff to perform a more detailed review of various aspects of the WIC program, as initially referred to in my letter to you dated January 30, 1978, and subsequently discussed by our respective staffs.

In this connection, GAO should obtain information on the nature and frequency of services provided to WIC participants, including nutritional education efforts, health services, and tailoring of food packages to meet WIC participant needs. Such information would be useful in the Subcommittee's review of the Fiscal Year 1980 WIC appropriation request, at hearings likely to be held sometime in February 1979.

With best wishes.

Yours very truly,

THOMAS F. EAGLETON, Chairman
Subcommittee on Agriculture, Rural
Development and Related Agencies

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